



BRIDGE2HOME
IMPACT REPORT



Housing Affordability and
Community Revitalization



EXECUTIVE SUMMARY

Wake County continues to experience rapid population growth, increasing housing costs, and a shortage of affordable housing, putting more households at risk of housing instability and homelessness each year. In response to these challenges, Wake County's Housing Affordability and Community Revitalization Department (HACR) created the Bridge to Home model as a coordinated, housing-focused approach to homelessness that combines evidence-based service delivery and flexible financial assistance to promote positive outcomes. What was originally an American Rescue Plan Act (ARPA) pilot is now a permanent Wake County framework in ending homelessness.

Building upon **Bridge to Home: a Mid-Program Analysis**, this report examines cumulative program and system-level outcomes through 2026 since implementation in 2022. Using standardized HMIS reporting to capture partner agency outcome data, system performance measures, and client feedback, this analysis takes a deep dive into the tenants of the Bridge to Home model and evaluates its effectiveness.

Since implementation, Bridge to Home agencies have substantially expanded their reach, **serving 86% more clients** than during the baseline period, a metric mirrored by a 62% increase in individuals experiencing homelessness for the first time in Wake County. During the performance period B2H partners have **increased exits to permanent housing year-over-year on average by 39%** and maintained returns to homelessness rates despite serving and housing more clients each year. This analysis also identified opportunities for continued refinement. While Bridge to Home has strengthened specialized service delivery through roles

such as SSI/SSDI Outreach, Access, and Recovery (SOAR)-certified staff and Housing Navigators, expanding and improving the tracking of income and benefits-related outcomes will further support program evaluation and strengthen client outcomes. Together, the successes and opportunities identified throughout this report provide a foundation for continued program improvement and long-term system impact.

Wake County's findings highlight how Bridge to Home has evolved from an innovative pilot program to a sustainable, evidence-based model that continues to strengthen Wake County's homeless response system. Every day experiencing homelessness is a day too many. Bridge to Home gives providers the capacity to break down barriers and ensure that all Wake County residents have a safe place to call home.





INTRODUCTION

In 2022, the **Wake County Department of Housing Affordability and Community Revitalization (HACR)** piloted Bridge to Home (B2H) as a comprehensive approach to address homelessness and affordable housing gaps in Wake County. Initially supported by a \$10.5 million allocation from the American Rescue Plan Act (ARPA), Bridge to Home translated lessons learned from the County's Hotels to Housing (H2H) initiative into a structured service framework designed to make homelessness rare, brief, and non-recurring.

ARPA funding provided the opportunity to strengthen service provider capacity by increasing direct client assistance, integrat-

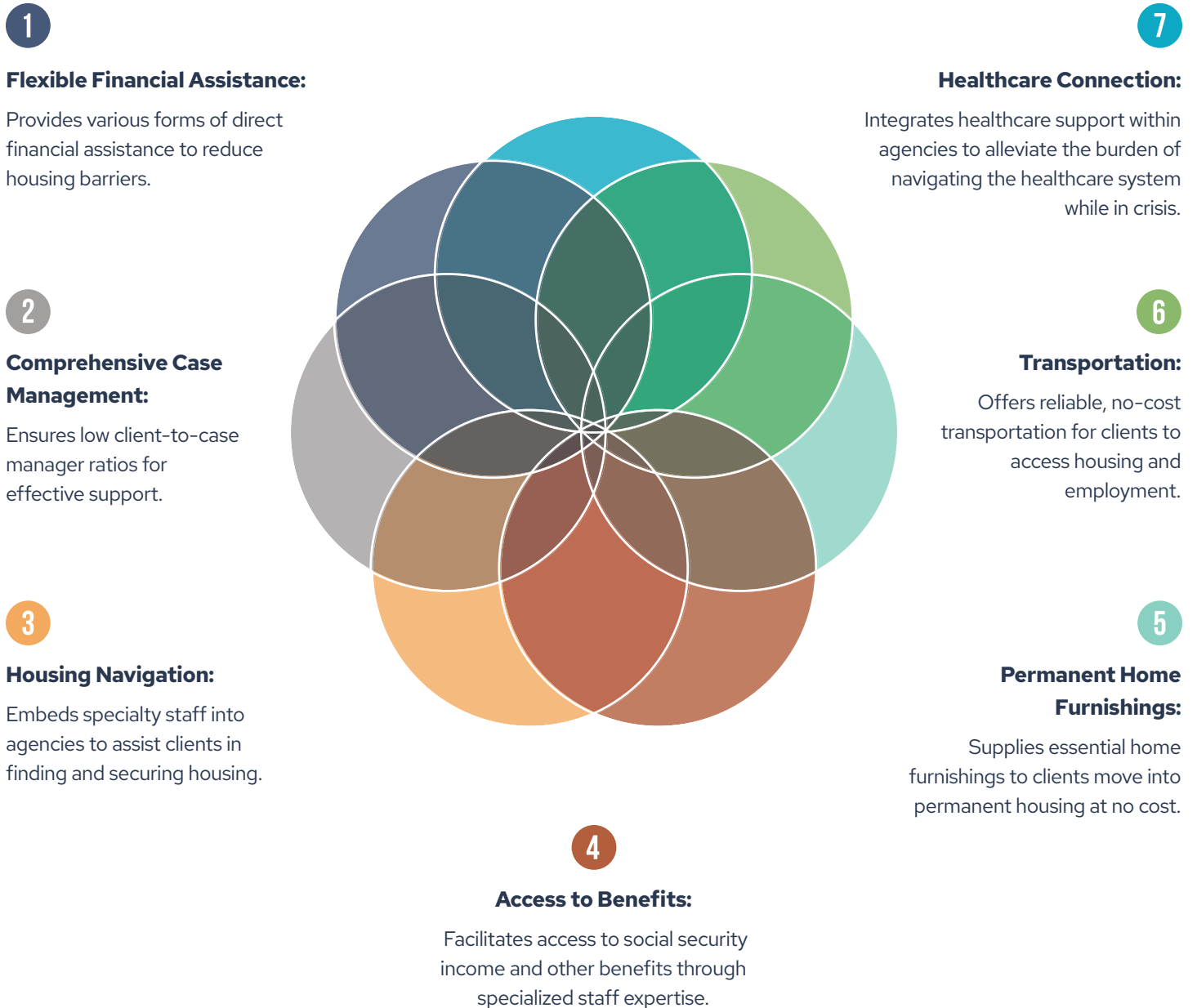
ing specialized staff, and supporting operational needs. Through coordinated implementation, performance monitoring, and partnership, Bridge to Home demonstrated measurable improvements in both agency-level and system-wide outcomes. As a result, what began as a time-limited federal recovery stopgap transitioned into a sustained County-funded investment, reflecting Wake County's commitment to ensuring that every resident has a safe and affordable place to call home.



Through coordinated implementation, performance monitoring, and partnership, **Bridge to Home** demonstrated measurable improvements in both agency- level and system-wide outcomes.

Bridge to Home Overview and Partner Acknowledgement

The Bridge to Home model equips partner agencies with the resources and performance infrastructure necessary to deliver housing-focused services. The model is structured around seven service pillars:



In December of 2023, HACR published a comprehensive analysis of the program’s initial implementation and early outcomes in Bridge to Home: A Mid-Program Analysis. Along with performance, that report details the development of the seven service pillars and examines challenges presented in the early stages of implementation. While the mid-program analysis provides a full description of the model’s design and theoretical framework, this report builds on that foundation by examining cumulative cohort and system impact since its launch as a pilot in 2022.

Bridge to Home partners include multiple local agencies specializing in various homeless interventions and services, ensuring comprehensive and specialized support for different populations.



Family Emergency Shelter



Youth Street Outreach and Shelter



Women’s Drop-in and Emergency Shelter



Emergency Shelter via Host Homes for college students



Emergency Shelter for individuals fleeing or attempting to flee domestic violence



Day Center Services



Permanent Home Furnishings



Drop-in and Emergency Shelter for Families



Day Center Services for Women & Men’s and Women’s Drop-in Shelter



Joint Funder



Street Outreach and Rapid Rehousing Services



Emergency Shelter for Women

State of Housing and Homelessness in Wake County

Wake County is growing rapidly, faster than the rest of North Carolina and most counties across the United States. Home to over 1.2 million residents, the County’s population has grown more than 20 percent since 2015, compared to 11 percent statewide. This economic and population growth has been driven primarily by new jobs: 150,000 positions have been added in the past decade, and employment is projected to grow by one-third by 2035.

While growth has brought prosperity, it has also intensified pressure on housing, which the market alone will not be able to meet. By 2035, Wake County will need 230,000 additional housing units, yet only 154,000 units are projected to be built. Even as current housing stock grows, median rent reached \$1,648, an increase of nearly 50 percent since 2015.

Most of the County’s low- and moderate-income workforce cannot afford to live here. While high-income earners (like lawyers and engineers) can afford almost \$800 more than the median

rent, moderate-income workers (such as teachers and construction workers) can afford \$431 less than the median rent, and low-income workers (including retail employees and servers) fare even worse, affording \$775 less than the median rent.

This mismatch between housing costs and what residents can afford leaves the current stock unable to meet the greatest needs. In 2024, renters earning under \$50,000 faced a shortage of roughly 67,000 units, while those earning over \$75,000 experienced a surplus of about 50,000 units (Figure 1).

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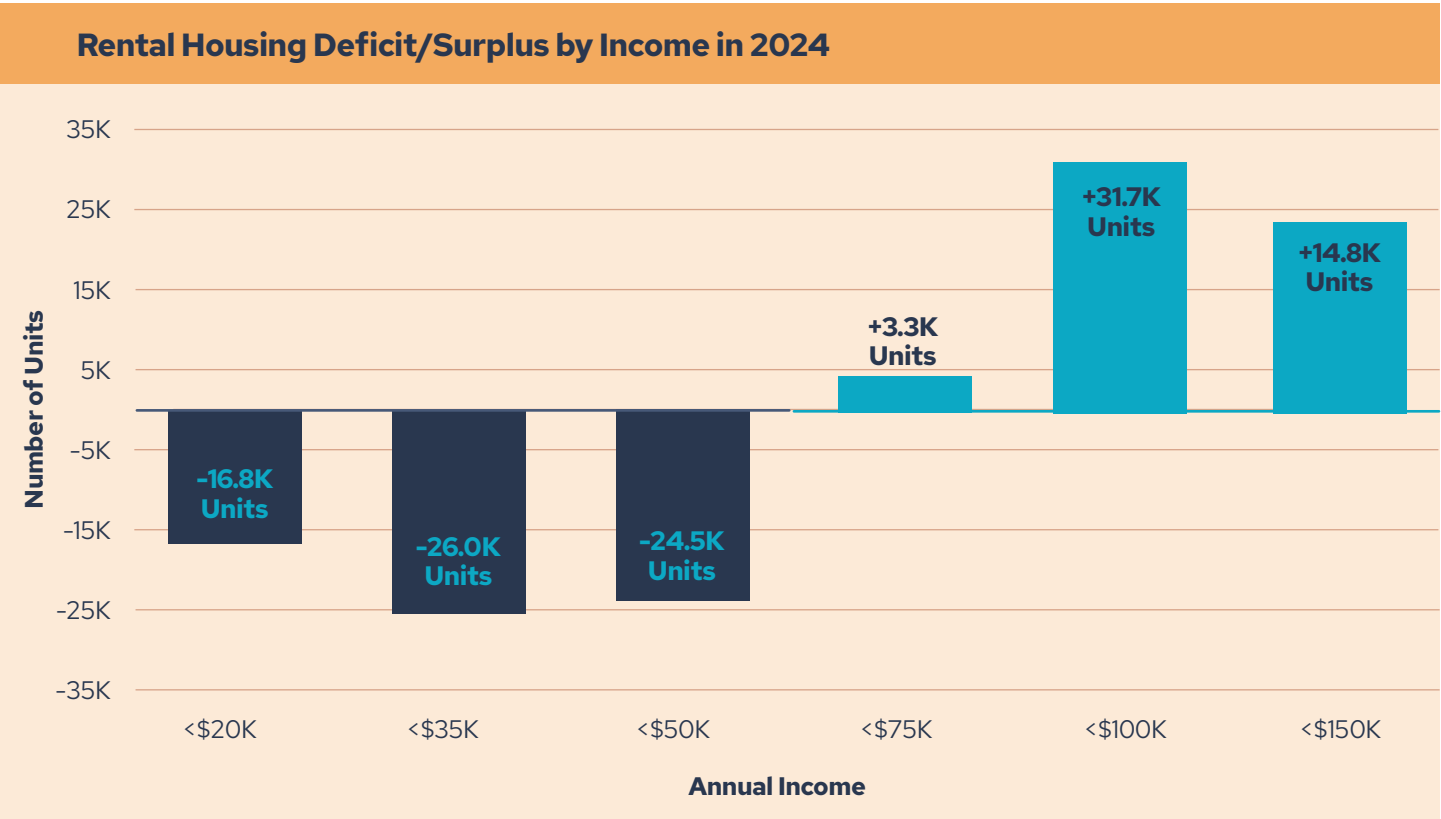


Figure 1: Rental Housing Deficit/Surplus by Income, ACS 5-Year 2020-2024

The imbalance of available housing stock and what residents can afford forces many residents into housing that is unaffordable or unsuitable, increasing the number of cost-burdened residents (i.e., those spending more than 30 percent of their income on housing) or pricing people out of Wake County altogether. As housing costs continue to outpace income and affordable housing remains in short supply, more households are at risk of experiencing housing instability and homelessness.

Local data reflects this growing pressure. In 2026, the Point-in-Time (PIT) Count recorded 1,150 people experiencing homelessness in Wake County, with 27 percent of those experiencing unsheltered homelessness, and 26 percent experiencing chronic homelessness (Figure 2). Over the course of the year, 5,264 individuals experienced homelessness.

Homelessness is not only a housing crisis, but also a system capacity issue. When individuals cycle between shelters, emergency rooms, jails, and hospitals, the result is instability for households and high, avoidable public costs for the community. This shows that achieving long-term stability requires more than just housing alone. It also requires access to supportive services that address the complex needs many individuals experience while exiting homelessness.

For those managing behavioral health needs, chronic health conditions, or disabilities, services such as case management,

Decades of research point to a single conclusion: **Homelessness is solvable.** When a community shares that informed belief, commits to proven practices, and backs that goal with the right resources, they can overcome even the most challenging economic and environmental conditions.

healthcare coordination, behavioral health support, and life-skills assistance help households maintain housing and avoid crises. Lasting stability requires a coordinated approach that pairs access to housing with the appropriate level of supportive services.

In this environment, a well-coordinated homeless service system is essential. As housing costs continue to outpace income and affordable housing remains in short supply, more households are at risk of experiencing housing instability and homelessness. Bridge to Home was developed as a response to these broader housing issues, providing a coordinated and housing-focused service model to help households quickly resolve their homeless episode and achieve long-term stability.

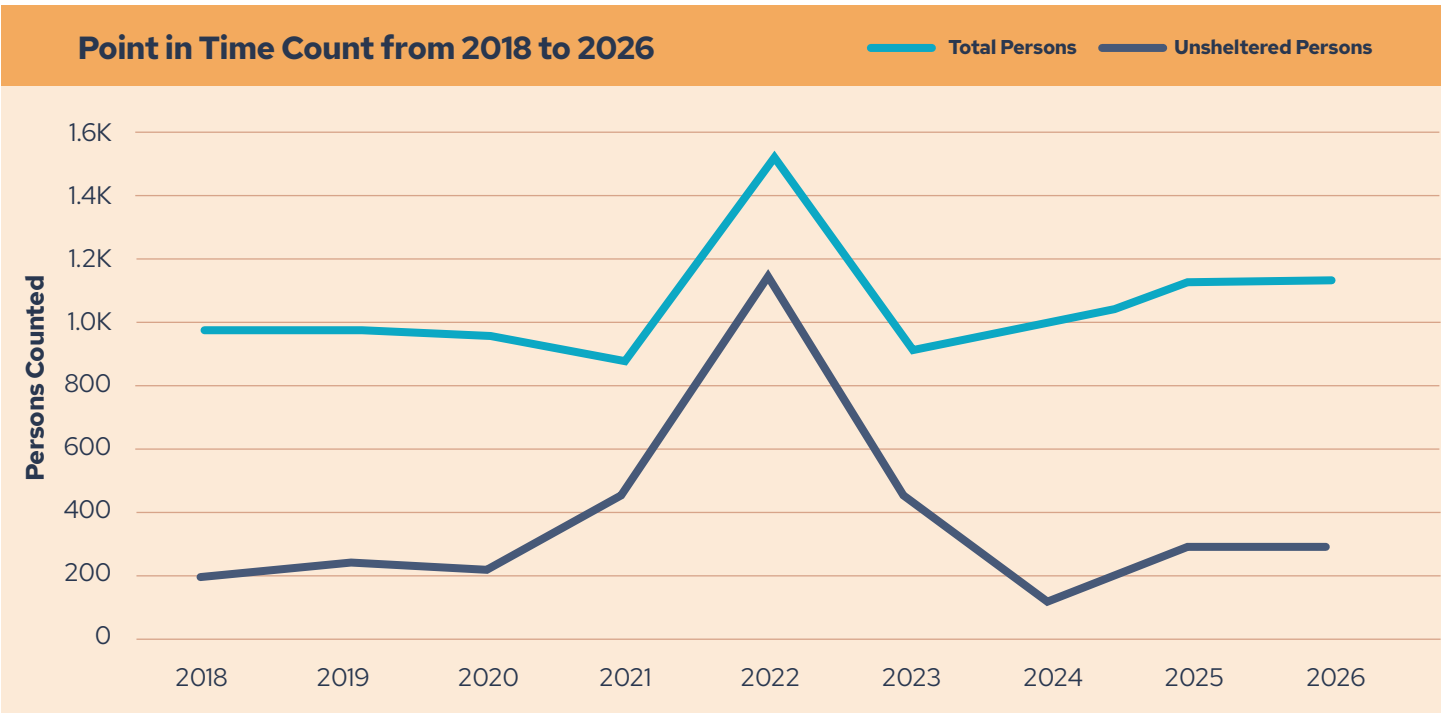


Figure 2: Point in Time Count from 2018 – 2026, HUD and NC-507 Continuum of Care

Integrated Service Delivery

While each pillar was selected individually based on experience, community feedback, and best-practice research, the model is designed to function as an integrated service framework. The effectiveness of the model relies on the coordination and commitment to each of the pillars. Regardless of the high acuity and barriers presented with clients, Bridge to Home partners use the pillars to address the full array of client needs.

When implemented together, these interventions create a coordinated pathway to stability. Once a client is engaged, case managers establish the foundation for consistent and housing-focused goal setting. Case managers build rapport with their clients and identify immediate barriers while coordinating services internally and externally as needed.

As clients begin to access services and enroll in appropriate programs, specialized staff are able to address complex barriers. Housing Navigators work directly with landlords and property management to identify available units and guide clients through the housing search and application process. SSI/SSDI Outreach, Access, and Recovery (SOAR)-certified staff assist eligible clients in accessing benefits to increase household income, and health-care engagement specialists or on-site nurses coordinate access to medical and behavioral health services.

Flexible Financial Assistance

Flexible financial assistance serves as the backbone of the model. At the heart of this pillar is the acknowledgment that a core cause of homelessness is a lack of money and the availability of flexible financial assistance allows providers to meet recipients where they are and with the means to address their immediate needs.

At system entry or at any point while problem-solving with a client, agencies may deploy flexible financial assistance to remove a barrier or resolve a homeless episode. Whether it is an application fee, security deposit, a payment in arrears, a car repair, prescription assistance, or an uber ride to a job interview, flexible financial assistance fills the gap.

What distinguishes this approach is not only the availability of financial assistance, but the true flexibility of how it is used. Without rigid eligibility requirements, service caps, or predefined uses, providers are able to respond quickly to the unique and often urgent needs of each client. Wake County staff encourage agencies to apply the financial assistance with creative solutions toward an individual's housing need.

Within the model, flexible financial assistance operates in tandem with the other pillars. While case management establishes a plan and specialized staff tackle underlying drivers of instability, financial assistance provides the immediate means to act.

In this way, financial assistance is not a standalone intervention, but a tool that activates and reinforces each component of the model. This combination of flexibility and coordination allows providers to simultaneously respond to urgent financial needs while working with clients to address the root causes of their housing instability.

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Housing Navigation

Research has shown that homelessness is fundamentally a systemic and structural housing problem; cities with higher housing costs and lower housing availability see higher per capita rates of homelessness. In **Homelessness is a Housing Problem**, Colburn and Aldern argue that "Individual risk factors help account for who in a given city might lose their housing at any given point in time, but housing markets—rents and vacancy rates—set the context in which those risk factors are expressed."²

A job loss, medical emergency, or another large, unexpected expense may place a household at risk of housing instability. In a housing market with a healthy supply of housing and lower rents, many households can recover from that shock without losing housing. In a housing market with high rents, low vacancy, and a limited number of affordable options, the same setback is more likely to result in a loss of housing or other insecurities.

The housing navigation pillar does not seek to fix the underlying housing shortage. Rather, it aims to mitigate some of the impacts of a strained housing market by helping clients navigate complex housing systems and overcome barriers to obtaining and maintaining housing even with broader market constraints.

Clients with additional barriers, like having low- or no income, eviction history, or a criminal record, face additional difficulty finding a suitable home. Housing navigation is designed to help reduce administrative and structural barriers to housing, supporting those experiencing homelessness and housing instability. The goal is to ensure that households can successfully access and retain housing, even with broader market constraints.

Housing navigators are specialized case managers who work directly with clients to find, secure, and retain housing suited to their individualized and specific needs. The Bridge to Home model ensures that each funded agency includes at least one dedicated Housing Navigator as part of its service model. Housing Navigators support housing access through application assistance, housing search and placement, landlord coordination and mediation, service connections, and documentation.³ They work closely with Wake County's **Landlord Engagement Unit (LEU)**, which partners with housing providers through an incentive program to increase the supply of affordable housing options.

Clients who worked more frequently with Housing Navigators had higher rates of housing stability and employment success.⁴

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Qualitative data also indicated that Housing Navigators helped clients remain connected to service systems and access resources that might be difficult to obtain, and interviews of recently housed individuals speak to the validity of this research. Clients described Housing Navigators' ability to identify landlords and homes they were unable to find independently. One participant explained that they were connected to a private landlord who approved their limited credit history; a barrier that impacts many households seeking housing in Wake County regardless of their housing status.

But it's not just housing and employment outcomes that are affected by Housing Navigators, often it is the social-emotional impacts of housing navigation mentioned most by clients. While meeting immediate physical needs is always paramount, clients reported reduced stress, increased comfort and stability, and greater confidence in navigating future challenges because of their relationships with Housing Navigators.⁵ These findings underscore the importance of housing navigation in advancing both measurable outcomes and participants' capacity to engage with support systems independently over time.

Having dedicated housing navigation specialists improves client engagement and access to services, ultimately supporting more successful housing outcomes. This approach leads to faster housing placements and improved stability, especially when implemented as a specialized function within a broader system.

Comprehensive Case Management

Comprehensive case management is a collaborative and client-centered approach that links those with complex needs to the services needed. People experiencing homelessness or housing instability face a range of interconnected challenges that extend beyond housing alone. Navigating the network of services can be difficult, particularly within systems that are robust yet fragmented, where requirements, timelines, and processes vary across providers. Without coordinated support, these barriers can delay or prevent successful housing placement and long-term stability.

Case managers address these challenges by serving as a central point of coordination for clients. Through regular and ongoing engagement, case managers build relationships with clients, develop tailored plans with clear housing goals, and connect clients to appropriate and proportional resources. This approach both improves access to services but also ensures that these services are aligned and responsive to the client's needs, supporting more effective progress toward housing stability.

Delivering this level of support requires manageable caseloads. When case managers are responsible for too many clients, their ability to provide consistent and coordinated services will be more difficult. B2H addresses this by funding a housing-focused case management ratio of no more than 25 clients to one case manager.

Research shows that lower caseloads and intensive, relationship-based case management work improve client engagement, increase utilization of services, and lead to more stable housing outcomes.⁶ Reasonable caseloads reduce staff burnouts by allowing case managers to better respond to crises and maintain consistent contact to support clients.

This research was reflected in client interviews, where individuals consistently described how the relationships built with case managers were one of the most valuable aspects of their experiences navigating the system and exit to permanent housing. Participants often attributed their successful transition to housing not just to the services they received, but to staff who remained engaged, "kept their word," and "followed through."

The Bridge to Home model is intentionally designed to support this level of engagement. Client feedback reinforces the value of integrating specialized roles into agencies and creating capacity for each provider to focus on their area of expertise. By distributing responsibilities across specialized roles, case managers are able to devote more time to building trust, have the capacity to respond to emergent needs, and maintain meaningful relationships as clients work toward their housing goals.



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Healthcare Connection

Many individuals experiencing homelessness are managing overlapping health challenges; physical health needs, mental health needs, and substance use often coexist and directly impact their ability to obtain and maintain housing. In many cases, these challenges contribute to the initial loss of housing and continue to worsen without access to consistent care.⁷

Nearly a quarter of people experiencing homelessness have a disability, and certain health conditions are more common among people experiencing homelessness. For example, people experiencing homelessness are five times more likely to have HIV, five times as likely to have hepatitis, four times as likely to have a stroke, three times as likely to have dementia, and twice as likely to have COPD.⁸

Without intentional healthcare connection, these needs are often addressed only in crisis: through a trip to the emergency room, ambulance services, or law enforcement intervention, rather than through coordinated, preventative care. This increases instability and the likelihood of prolonged homelessness for individuals and increases the system-wide costs of addressing homelessness.

Health is fundamentally tied to housing. Healthcare access at every stage of a housing crisis significantly improves long term health and housing outcomes. The need for embedded healthcare within housing interventions is increasingly reflected in both national and state-level research.

A 2026 study found that veterans who participated in homelessness prevention programs experienced lower inpatient healthcare costs and reduced mortality rates, reinforcing evidence that housing stability is a preventative healthcare intervention.⁹

Our neighbors in Virginia have also found success in integrating healthcare and supportive services into Permanent Supportive Housing (PSH) models. According to a 2025 report from the Virginia Department of Behavioral Health and Development Services, individuals entering PSH experienced an almost 74 percent reduction in state psychiatric hospital utilization in the year following move-in.¹⁰ Between 2016 and 2025, the state estimates that they avoided nearly \$42 million in hospital costs when comparing utilization one year before and after placement in PSH.

The Bridge to Home model acknowledges this interconnection, and healthcare operates alongside case management, housing



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navigation, and financial assistance to remove barriers in real time. Once a client is engaged, case managers identify health-related needs as part of an initial assessment and ongoing goal setting. Specialized staff, such as healthcare engagement specialists, nurses, or mental health clinicians, then work in parallel to navigate the complexities of health management.

By addressing these needs as they arise, rather than as they escalate, the Bridge to Home model supports sustainability. Establishing relationships with primary care providers, supporting medication adherence, and coordinating follow-up care all contribute to a more sustainable transition into housing. The model's approach recognizes that resolving a homeless episode requires more than securing a unit, it requires stabilizing the underlying factors that can lead to future instability.

Access To Benefits

Connecting individuals to housing is central to the work of ending homelessness, but achieving long-term stability often requires more than a lease. Providers play a critical role in connecting individuals to mainstream benefits and services that increase income, improve access to food, and address other barriers to stability. Evidence shows that maintaining continuous contact between clients and staff is a good way to remove barriers to benefits.¹¹

For those experiencing or at risk of homelessness who have a disabling mental illness, co-occurring substance use disorder, and/or other medical conditions, access to income and healthcare supports such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) can offer a pathway towards permanent housing. For individuals who are unable to work due to age or disability, these benefits may represent the most viable pathway to increasing household income and accessing permanent housing. In addition to SSI/SSDI, individuals may also benefit from connections to other resources including Supplemental Nutrition Assistance Program (SNAP), Medicaid, and Work First Family Assistance, which can help address immediate needs and support longer-term stability.

Despite their importance, accessing SSI/SSDI benefits is often a complex and time-intensive process. Applications require extensive documentation, coordination with medical providers, and the ability to navigate a highly technical system. These are barriers that can be particularly difficult for individuals experiencing homelessness. This feeds into the “non-take-up problem”, a trend where individuals or households “are not claiming the benefits and services to which they are entitled.”¹² This includes both financial and social services, and researchers argue unmet needs result from a lack of awareness, barriers to accessing services, or other failures within the service model to connect individuals to proper resources.¹³ As a result, many eligible individuals face delays or are denied benefits altogether, prolonging their housing instability.

SOAR (SSI/SSDI Outreach, Access, and Recovery) addresses these barriers by providing specialized knowledge to guide clients through the application process and connect them to eligible benefits. SOAR-trained staff help clients gather documentation, like state-issued identification, birth certificates, and Social Security cards, coordinate medical records, complete applications, and navigate the appeals process when necessary.

Approximately half of individuals experiencing homelessness are living with a disability, indicating that a significant portion of this population may be eligible for SSI/SSDI benefits.¹⁴ By leveraging SOAR-trained staff to support the application process, providers can increase access to income while allowing case managers to focus more directly on securing housing.

Although the Social Security application process can take up to 12 months, the use of a specialist has been shown to increase initial approval rates while reducing the time it takes for applications to be processed. By streamlining access to disability benefits and connecting individuals to other resources, this approach helps individuals stabilize income more quickly and strengthens their ability to obtain and sustain housing.

For those experiencing or at risk of homelessness who have a disabling mental illness, co-occurring substance use disorder, and/or other medical conditions, **access to income and healthcare supports** such as Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) can offer a pathway towards permanent housing.

Transportation

Transportation is an enabling service within the Bridge to Home model, ensuring that clients can consistently access the resources and opportunities necessary to secure and maintain housing. While often overlooked as a core factor in instability, transportation directly influences whether key housing-focused activities are successful.

Partners use transportation assistance to facilitate participation in housing-related activities and service connections. This may include transportation to employment interviews, work, medical appointments, and benefits-related obligations like obtaining vital documents. In many cases, the absence of reliable transportation can delay or completely prevent progress toward housing stability.

Transportation also plays a key role in diversion and rapid exit strategies. In situations where safe and appropriate alternative housing options exist, such as reunification with family, transportation assistance can provide an immediate resolution to a housing crisis. Bridge to Home partners fund bus, train, or plane tickets to reconnect clients with support systems in any location, diverting them altogether or shortening the length of time spent in a shelter. Partner staff have the ability to deploy these funds immediately, allowing households to quickly stabilize without prolonged system involvement.

Throughout engagement clients receive assistance as needed, including gas cards, bus passes, ride-share services, and, when necessary, more tailored solutions such as vehicle repairs. These supports are deployed strategically based on individual client circumstances, with the goal of removing logistical barriers that interrupt momentum toward housing.

Client feedback reinforced that transportation assistance functioned as more than a means of travel, but enabled continued engagement and goal achievement throughout the housing process. Interview participants described transportation assistance that allowed them to attend apartment viewings, employment opportunities, get their kids to school in order to arrive at work on time. One participant recalled how receiving a bus pass ensured that they were able to continue accessing services at a partner agency and commute around the County while working toward their goals. These experiences illustrate how relatively small transportation investments can prevent interruptions that may



Without reliable transportation, coordinated efforts can stall, even when all other supports are in place. This approach eliminates the financial burden associated with moving into a new home while promoting independence, personal choice, and a greater sense of ownership as clients start their next chapter.

otherwise delay or derail a client's path toward stability.

Much like flexible financial assistance, the integration of transportation within the model reinforces the effectiveness of other pillars. Case Managers depend on consistent engagement to move housing plans forward and address emerging barriers in real time. Without reliable transportation, coordinated efforts can stall, even when all other supports are in place. This approach mitigates the logistical burden associated with moving into a new home while promoting independence, personal choice, and a greater sense of ownership as clients start their next chapter.

Permanent Home Furnishings

Successful transitions into permanent housing require more than simply securing a lease. The inclusion of this pillar ensures that clients exiting homelessness have access to essential household items needed to establish a safe and functional home they can call their own. Through a partnership with the Green Chair Project, clients receive home furnishings at no cost and are able to browse the agency's showroom to personally select items that best meet their needs. By combining financial support with client choice, the pillar reduces move-in costs while helping households create homes that reflect their preferences and support long-term stability.

Recently housed clients demonstrated that the impact of this pillar extends beyond the provision of basic household items. Individuals spoke about the ability to return to everyday routines, being able to cook for themselves and their children, and relishing the peace and safety of their own space. They recalled how they were able to pick up old hobbies and fell back into a pattern of enjoying stress-free time with their families. Permanent housing is more than just a physical space. Establishing a home that supports personal well-being is a vital component of long-term housing stability.



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Diversion

Diversion is an intervention that aims to resolve a housing crisis before a household enters the homeless system altogether. Instead of connecting individuals to emergency shelter or longer-term programs, staff engage individuals in structured conversations to understand their circumstances and identify existing supports and housing options. When diversion is not a safe or appropriate option, households continue through coordinated entry and are connected to shelter or other services as needed.

Although diversion is not one of the seven pillars, it is an integral practice that complements the model's housing-focused approach. Recognizing the value of resolving housing crises as early as possible, Wake County has incorporated diversion into the Bridge to Home Learning Cohort, where partner agencies receive training on diversion tactics, partic-

ipate in discussions of real-world scenarios, and share effective strategies with each other. This collaborative approach has helped establish diversion as a routine component of client engagement and encouraged staff to explore safe housing alternatives.

To improve the ability to track diversion outcomes, Wake County created a separate "Diversion" service transaction for agencies to utilize. Since the deployment of this option, 57% of clients who received diversion assistance did not return for additional homeless services. With the number of people entering the homeless system rising each year, effective diversion tactics become increasingly vital. While diversion is not appropriate for every household, early problem solving and targeted assistance will reduce homeless episodes and preserve system capacity.



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PROGRAM ANALYSIS

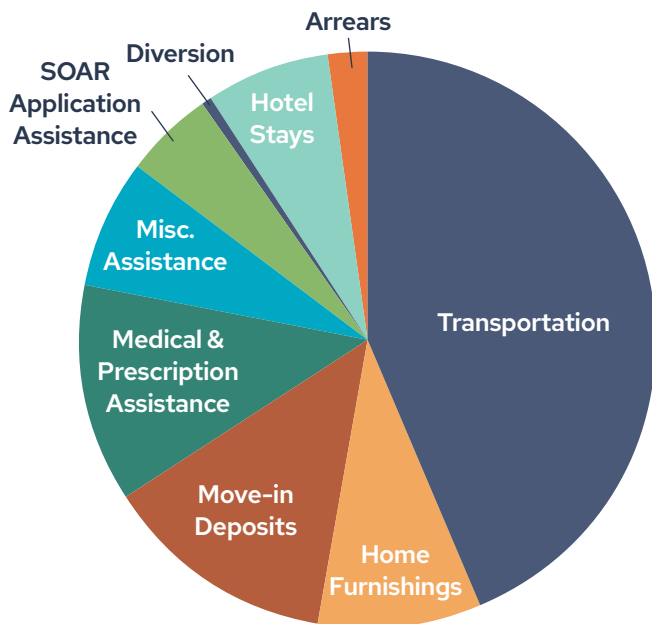
Introduction

Bridge to Home implementation and outcomes are assessed using a combination of program and system-level data and qualitative feedback from participants. A key component of this framework is standardized reporting across partner agencies. This allows for consistent tracking of service delivery and client outcomes.

All Bridge to Home partner agencies participate in the local Continuum of Care (CoC), Raleigh/Wake NC-507, and record client-level data in the Homeless Management Information System (HMIS). Agencies utilize a standardized set of Bridge to Home service transactions that align with the model's seven pillars, tracking real-time and program-life client assistance that captures both the service type and cost. In addition to services,

agencies document key client outcomes including exits to permanent housing, increases in income and benefits, and instances of diversion. Agencies report this information on a monthly basis using two HMIS reports: Attendance by Days Served for service transactions, and an Annual Performance Report for client outcomes. To supplement program level data, model impact is evaluated by analyzing System Performance Measures from the broader CoC. These metrics provide important context for understanding how B2H outcomes compare to community-wide trends, and help determine how the program affects the community as a whole. Standardization across agencies is critical to ensure that data can be aggregated and meaningfully analyzed at both the program and system level.

B2H By the Numbers



21,110+ TOTAL SERVICES PROVIDED

SERVICE	HOUSEHOLDS
Transportation	8,978
Move-in Deposits	2,832
Medical & Prescription Assistance	2,639
Home Furnishings	1,925
Misc. Assistance (documents, job training, basic needs)	1,511
Rental & Utility Assistance	1,471
SOAR Application Assistance	957
Arrears	492
Diversion	120



Qualitative Feedback

To complement the quantitative analysis throughout this report, Wake County partnered with PhD candidates in Duke University School of Medicine's Occupational Therapy Program. With the help of Bridge to Home cohort staff, they coordinated and conducted semi-structured interviews with a sample of individuals who had recently transitioned into permanent housing. The interviews were designed to explore participants' experiences navigating homelessness, engaging with services, and moving into their new home.

Responses were organized into recurring themes to provide personal context for the outcomes presented in this report. While the data gives insight into the community and illustrates program and system impact, these interviews serve as a reminder that each metric represents a person with a unique story, challenges, and successes. Participants reflected on both barriers they encountered and the support that helped them achieve stability. Relevant perspectives from these conversations are incorporated throughout the report to supplement quantitative findings.

Data and Outcome Evaluation

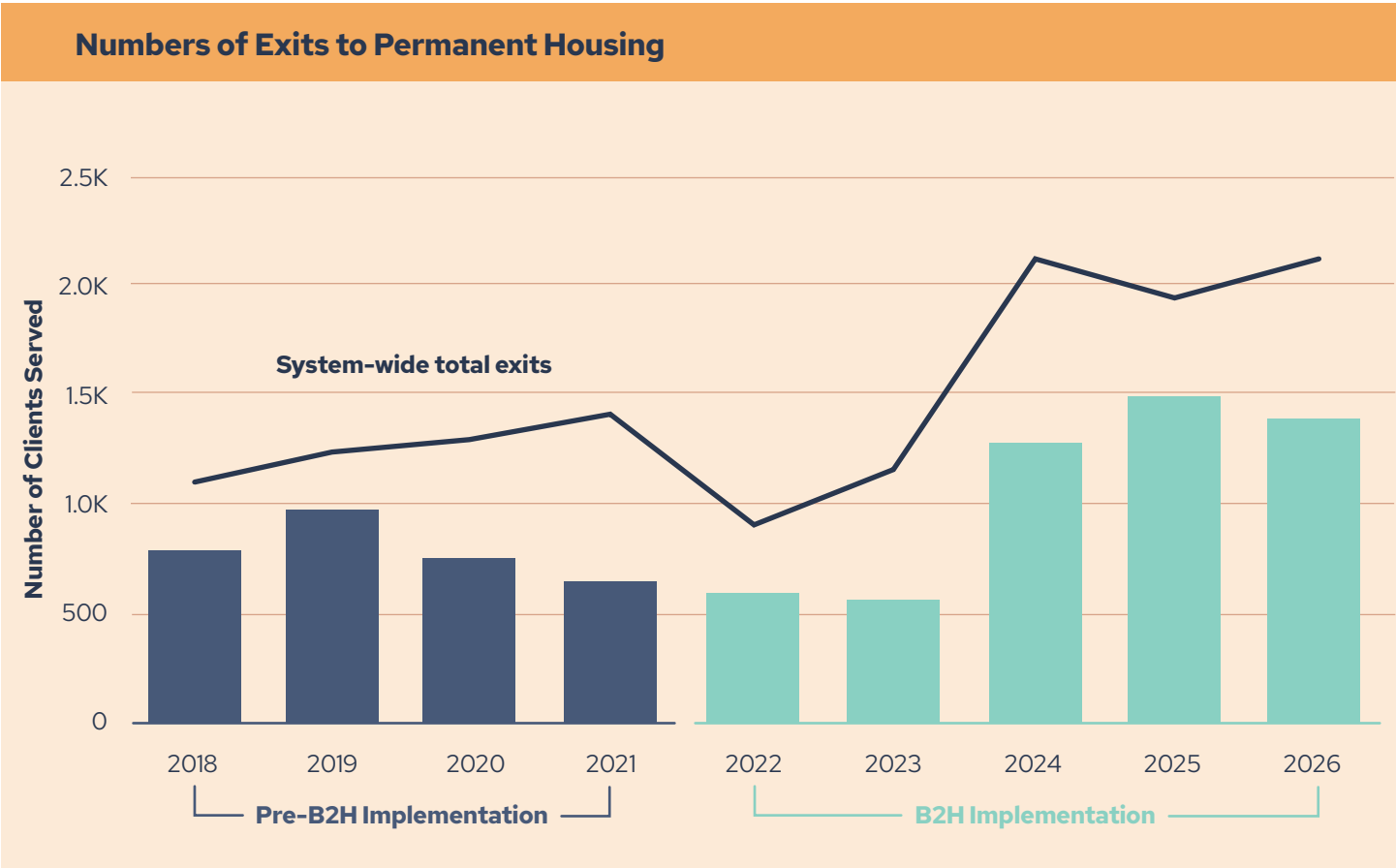
A baseline average was taken using data from 2018 to 2021. Data after 2021 are considered part of the full program analysis, building on the Mid-Program Analysis and adding recent data from 2025 and 2026. To understand the program's results, data from 2018 to 2026 was pulled and was compared to both pre-program and system-wide trends.

To assess the impact of Bridge to Home, performance was evaluated across a set of metrics that reflect the core pillars.

- **Exits to Permanent Housing** measures the extent to which clients successfully move from homeless to permanent housing and reflects the combined impact of housing navigation, case management, and financial assistance.
- **Housing Success Rate** provides an overall measure of housing outcomes using the proportion of clients who successfully exit to permanent housing, showing the total impact of Bridge to Home pillars.
- **Returns to Homelessness** evaluates whether clients remain housed after exit and reflects the long-term impact of case management, financial assistance, benefits access, healthcare, and other support services.
- **Client Income at Exit** shows changes in the clients' financial stability and is tied directly to benefits access and comprehensive case management.
- **Exits with SSDI Income** measures the share of housing exits with SSDI income and reflects the access to benefits pillar in connecting clients with benefits to which they are entitled.

For context, Bridge to Home agencies have served over 40,000 clients between 2018 and 2026. Following implementation, the number of clients served by participating agencies increased by 70%. During the same time period, almost 60,000 clients were served system-wide, with Bridge to Home agencies accounting for a substantial portion of the total.

Exits to Permanent Housing



About the Data:

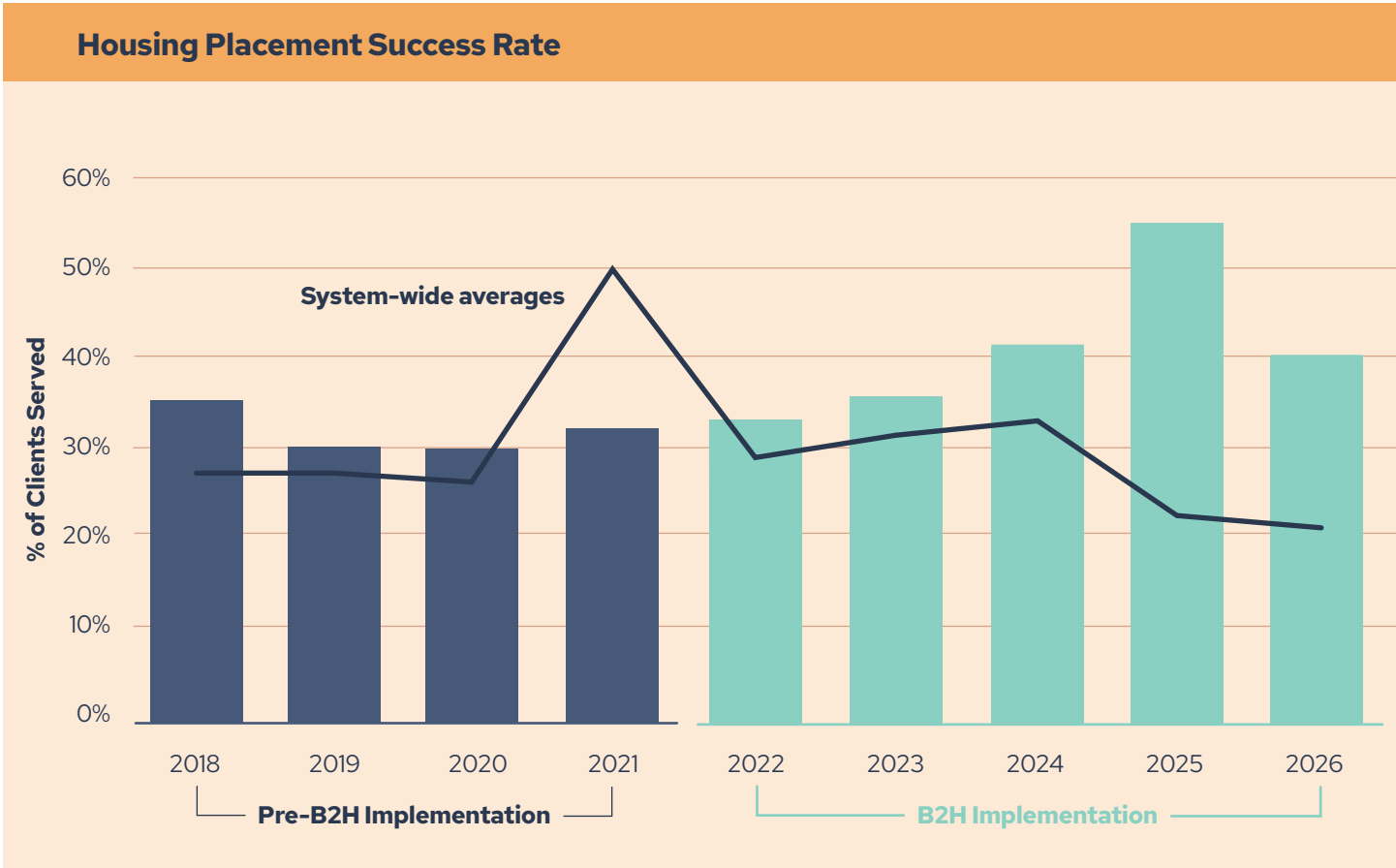
Bridge to Home agencies achieved an average year-over-year increase of 39% for clients exiting to permanent housing, compared to average annual increase of 14% during baseline years. Although the percentage of clients exiting to permanent housing declined slightly in the most recent year, the overall number of successful housing placements has remained substantially higher than pre-implementation years.

These trends should be considered alongside changes in both program scale and available resources. Since the baseline period, the number of clients served has increased by 86%, which includes a 62% increase in the number of individuals experiencing homelessness in Wake County for the first time. Between reporting years 2025 and 2026 Bridge to Home transitioned from an ARPA (American Rescue Plan Act) funded initiative to a sustained

but reduced County funded project. This downward shift in funding limited agencies' capacity for direct client assistance despite a growing population of residents in need of support. The decrease in clients exiting to permanent housing was proportionally smaller than the reduction in funding, showing that agencies continued to achieve positive housing outcomes.

Prior to joining Bridge to Home, participating agencies housed just over 3,000 clients between 2018 and 2021. Since joining the program, these agencies have housed nearly 6,000 clients from 2022 through 2026, almost doubling pre-implementation numbers. In total, almost 9,000 clients were housed between 2018 and 2026, and it is expected to continue growing as Bridge to Home expands.

Housing Success



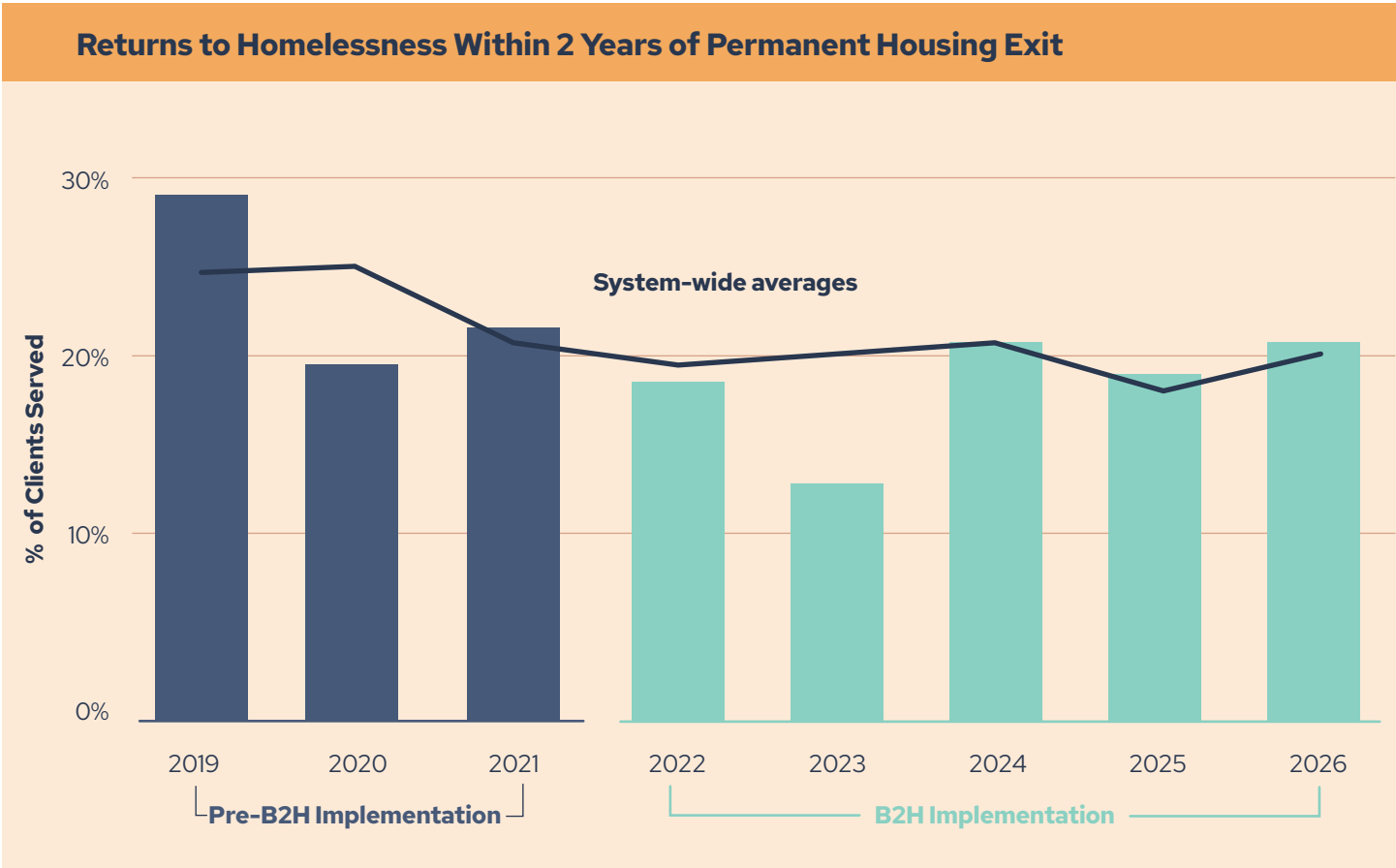
About the Data:

Bridge to Home agencies have consistently achieved higher rates of positive housing outcomes than system-wide averages. In 2026, 44% of clients served by B2H agencies exited to permanent housing, compared to 24% system-wide. This difference is notable given the growing number of clients served by B2H agencies over the implementation period.

Following B2H implementation in 2022, the share of enrolled cases resulting in a positive housing situation increased by an average of 13% year-over-year, compared to 12% prior to implementation. Despite some annual fluctuations, B2H agencies have maintained stronger outcomes throughout the implementation period.

This demonstrates that B2H agencies are not simply housing more people as enrollment grows, they are maintaining strong housing outcomes as the number of clients who need to be served increases. The broader system serves more clients overall, however, a smaller share exits to permanent housing. This is a testament to the pillar strategy; housing stability is achievable with the right resources and support systems in place.

Return to Homelessness



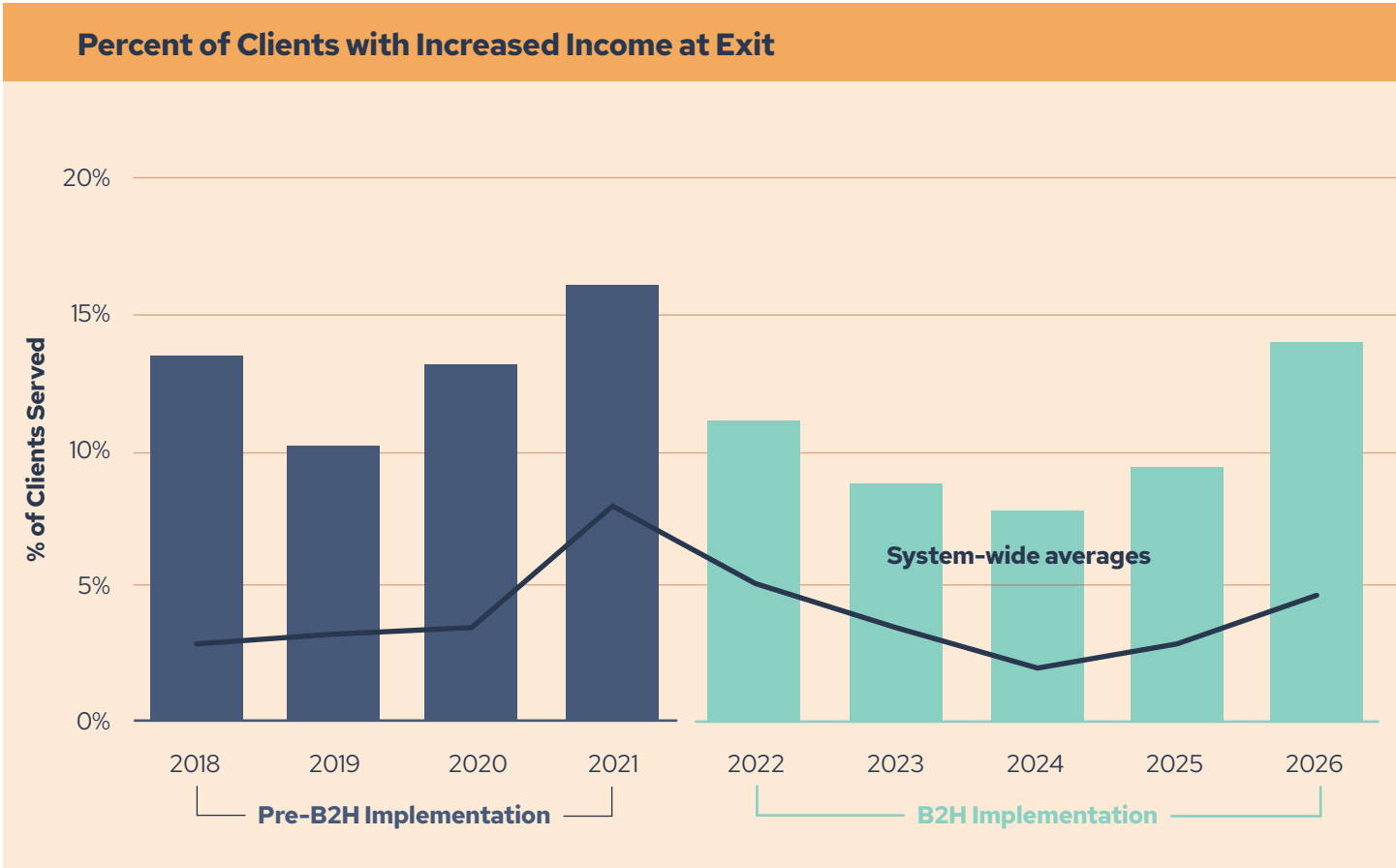
About the Data:

Returns to homelessness among B2H agencies have generally remained comparable to system-wide averages since implementation. While this data point suggests a marginal impact, it becomes more significant when the number of clients exited to permanent housing is considered.

Despite an increasing number of clients being served and successfully housed each year, the number of clients returning to homelessness within two years has not increased at the same

rate. During this period, the number of clients served increased by 23 percent, while the number of clients returning to homelessness among B2H agencies decreased by 1 percent. This suggests that B2H agencies have been able to expand housing placements without a corresponding increase in returns to homelessness. In the context of a tightening housing market and growing demand for affordable units, these findings highlight that the Bridge to Home program has contributed to the expansion of housing placements while maintaining housing stability over time.

Client Income at Exit



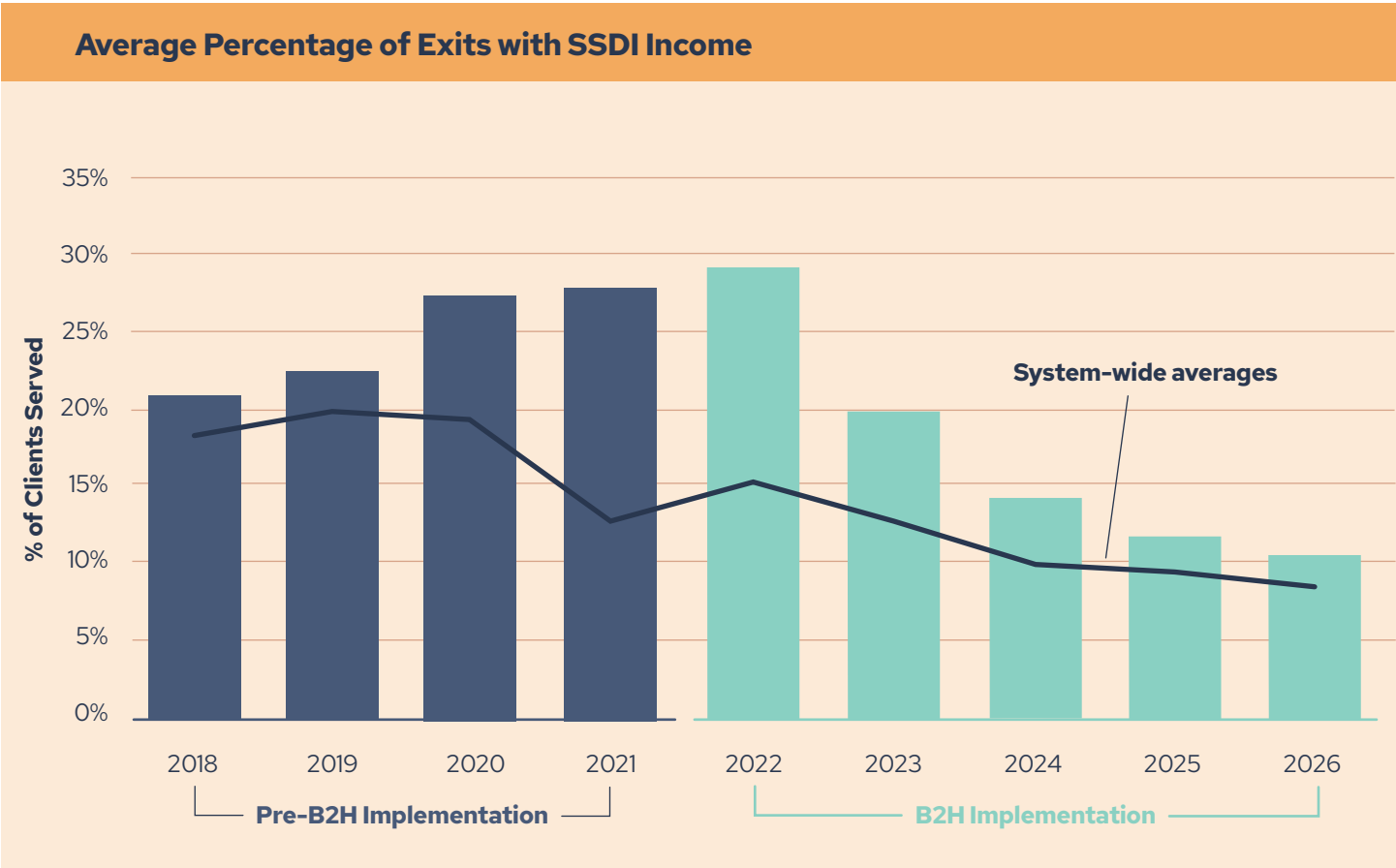
About the Data:

The percentage of clients exiting programs with increased income declined at the beginning of the B2H Implementation period, but has since rebounded considerably, with these exits now at their highest level since B2H implementation. The results are notable when compared to system-wide averages for clients exiting with increased income. While B2H programs have followed similar system-wide trends, the pillars continue to deliver results to clients more than at the system at large.

Prior to joining the Bridge to Home cohort, one partner agency did not have a dedicated SOAR specialist. Through the B2H initiative, they established this specialized role and expanded

their capacity to connect clients with benefits. Since the position was created, their specialist has secured more than \$230,000 in retroactive benefits for clients, providing households with critical financial resources that otherwise would have likely never been awarded, or may have taken much longer without the help of a specialist. Beyond the immediate financial impact following approval, they also represent a source of ongoing income that supports long-term stability.

Client Benefits at Exit



About the Data:

Since 2022, there has been a sharp decline in the share of clients exiting both B2H agencies and the system overall with SSDI income. Prior to B2H implementation, the number of clients exiting with SSDI income increased by an average of 12% year-over-year. This trend peaked in 2022 before reversing sharply, with the current year-over-year average declining by 20%. The similar decline among both B2H agencies and the system overall indicates that this is not a localized challenge but reflects broader barriers to accessing and maintaining SSDI income.

The decline in the percentage of clients exiting with increased income should also be considered in the context of the significant

increase in the number of clients served. As the system continues to contend with high numbers of clients, capacity is still being built out. At the same time, broader federal policy changes have created additional challenges for clients seeking to gain, increase, or maintain income. SSDI benefits were already difficult to obtain, and recent cuts and changes have created additional barriers for individuals who rely on these benefits.¹⁵ Continued investment will be important in building out more program capacity and strategies to contend with these challenges and ensure that clients are getting the resources for which they qualify.



LIMITATIONS & LESSONS LEARNED

Changing Landscapes

Five years of Bridge to Home partnerships have highlighted several considerations that may inform future program design, implementation, and evaluation. These lessons reflect the realities of deploying a coordinated, multi-agency homelessness response in a rapidly changing environment.

Throughout implementation partner agencies experienced varying levels of staff turnover, reinforcing the importance of ongoing training and technical assistance to ensure that service delivery remains consistent and program expectations are clear.

The transition from being an ARPA to County funded program represented more than just a reduction, it also sparked a change in funding priorities. While the former funding source afforded the County to invest in both direct pillar activities and broader operational capacity, the reduction put greater emphasis on the

need to prioritize direct client assistance and dedicated program staff. This was a difficult transition for many partners, however the shift focused agencies back to the core pillars and objectives of the model and reinforced the importance of a strong organizational infrastructure that can support long-term implementation.

As the broader federal funding landscape continues to evolve, so too does the availability and stability of resources that support homelessness services. Changes in federal funding, eligibility requirements, or program priorities create uncertainty or additional barriers for partner agencies which will influence their capacity to provide services. While this cannot be entirely avoided, future technical assistance can evolve to problem solve and reduce barriers when possible. Continuing to maintain a strong operational and data infrastructure can also help staff be better equipped to adapt to changing requirements.

Data Quality

This analysis relied primarily on HMIS data entry and standardized reporting submitted by partner agencies. As with any collaborative initiative, the quality of the analysis depends on consistent and accurate reporting across the cohort. Continued technical assistance and routine data quality monitoring is vital to ensuring Wake County is able to rely on the reported client outputs and outcomes.

As Bridge to Home continues to mature, there are opportunities to strengthen performance measurement for specialized services. In particular, tracking SOAR-related activities and associated client outcomes is an area for growth. Improving documentation of these services will provide a more comprehensive understanding of the impact of specialized roles, and intentional oversight by Wake County will lead to improved client outcomes.

Conclusion

The Bridge to Home framework has demonstrated how a strategically aligned, housing-focused system can effectively reduce homelessness and improve the lives of residents in Wake County. By integrating the seven pillars—flexible financial assistance, comprehensive case management, housing navigation, access to benefits, healthcare connection, transportation, and permanent home furnishings—into a collaborative approach, a community can help solve the underlying barriers towards someone’s housing stability.

The cumulative outcomes, across partner agencies, highlight the effectiveness of this model in comparison to the control groups:

- Higher exits to stable housing
- Stronger stability outcomes
- Improved income gains
- Increase in the number of residents served

Each pillar plays a critical role in these results, underscoring the importance of maintaining fidelity to the model in implementa-

tion. Bridge to Home has represented a significant investment into Wake County’s homelessness response system and has effectively helped stem the tide of the ongoing impact of housing affordability on Wake County’s most vulnerable homeless residents. Comprehensive investment across all seven pillars has proven to increase the community’s capacity to quickly and effectively stabilize individuals in housing. As Wake County advances its commitment to make homelessness rare, brief, and non-recurring, the Bridge to Home program will remain foundational toward that work.

Most importantly, the experiences shared by participants reinforce the central truth of this work: every data point represents a person, a family, a neighbor and **with the right support housing stability is possible.**





ACKNOWLEDGEMENTS

Wake County Department of Housing Affordability & Community Revitalization

The Wake County Department of **Housing Affordability and Community Revitalization** would like to thank our incredible staff who work to prevent homelessness, preserve and produce affordable housing, support vulnerable residents, and strengthen our neighborhoods.

HACR operates through five core divisions that touch different parts of the housing continuum. Each division provides direct services, makes strategic investments, and builds strong community partnerships to advance the work of the Department and expand housing opportunities across Wake County.

Our **Homeless and Prevention Services (HPS) Division** focuses on the beginning of the housing continuum by working with households or individuals to avoid or exit homelessness. The Division provides shelter and supportive services through the South Wilmington Street Center, delivers eviction prevention and housing stability assistance through Wake Prevent, and funds community partners through the Bridge to Home program to provide emergency assistance, street outreach, and rapid rehousing. HPS helps stabilize individuals and families while connecting them to longer-term housing solutions.

The **Permanent Housing and Supportive Services (PHSS) Division** combines affordable housing with supportive services to help individuals facing barriers to housing achieve stability, autonomy, and dignity. The PHSS Team provides pre-tenancy services, including outreach and engagement, housing search and application assistance, and move-in support. The Division also leads the Landlord Engagement Unit which partners landlords with renters. Once housed, PHSS continues to support tenants through a broad range of additional services like rental assistance, stabilization services, eviction prevention, crisis intervention, and connections to health care, education, employment, and other community resources.

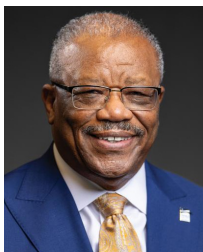
Veteran Services (VS) provides targeted support to veterans experiencing or at risk of homelessness. Through the Veterans Services Office and Veterans Homelessness Program, the division connects veterans to benefits, housing assistance, and stabilization resources to help them secure and maintain safe housing.

The **Equitable Housing and Community Development (EHCD) Division** focuses primarily on the creation and preservation of affordable housing at the end of the housing continuum. The Division administers rehabilitation programs for income-qualified homeowners, provides gap financing and preservation funding for affordable housing development, partners with DHIC on homeownership opportunities, and leverages County land for affordable housing through land disposition. EHCD works to strengthen and expand the supply of affordable housing for both renters and homeowners, supporting individuals and developers alike.

On the back end, the **Research, Data, and Systems (RDS) Division** works to strengthen the Department's work through analysis, partner coordination, and technical support. RDS also provides research and technical assistance expertise and works across the department to implement systems to streamline program implementation, reporting, and monitoring.

All five divisions work with Department leadership to address the most pressing housing needs across Wake County. Housing staff collaborate across divisions to design and deliver programs that respond to the community. This collaboration ensures that residents have direct and humanizing access to services regardless of their place in the housing continuum. By working together across programs and policy areas, the divisions are central to preventing and ending homelessness in Wake County.

We would like to recognize our Board of Commissioners for their commitment to addressing the critical issue of homelessness and affordable housing in our community.



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Footnotes

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