Winston-Salem/Forsyth County CoC (NC500) Plan to Serve the Unsheltered Homeless Population

Even before the COVID-19 pandemic placed a strain on the homeless assistance system and increased the number of unsheltered homeless people within our community, the street homeless population was a growing concern and key population in need of assistance for the NC-500 Continuum of Care. Between March 2020 and today, Winston-Salem/Forsyth County has seen a significant shift in how people experience homelessness. Since the on-set of the pandemic there has been a significant rise in the unsheltered population. Currently, the unsheltered population represents approximately 50% of people experiencing literal homelessness on any given night in our community. Pre-pandemic they represented 10-15% of the overall homeless population.

Over the last 60 days the Winston-Salem/Forsyth County CoC has engaged in intensive planning to develop a plan to address this shift in need and re-tool our homeless service system to better meet the needs of people who are unsheltered. In order to address this growing, need the CoC has developed this service plan to meet the needs of people who are unsheltered.

In developing the plan, the CoC has continued to place emphasis on its commitment to three core values including:

- Housing First as a solution to homelessness
- Commitment to continuous learning, evaluation, and improvement towards a racially just system of care and
- Developing and implementing a system wide culture, set of values, policies, and strategies to become a trauma informed system.

Current Data on Unsheltered Homelessness

Data collection related to the unsheltered population is always a challenge. Much of the information known depends on the consistency and quantity of street outreach staff in the community. The street outreach and coordinated assessment staff are continuously working to improve data collection and data quality to better understand the changes and needs of the unsheltered population and provide better services in the future.

Currently in Winston-Salem/Forsyth County, NC:

- There are 233 people on the unsheltered list (as of Aug 15, 2022). This number has varied between 220 and 250 for the last 18 months.

- Pre-pandemic the known unsheltered population varied between 50 to 0 people.

- Currently the unsheltered population is twice the size of the sheltered population, whereas pre-pandemic is represented 10-14% of the population.
- 68% are men and 31% are women.
- Over 50% of people on the street have a confirmed mental illness, and almost 25% have a confirmed substance abuse disorder.
- 89% of the people served by our CoC use the shelter system at some point during their period of homelessness.
- 11 (4%) identified as veterans.

A note on unsheltered families: pre-pandemic it was rare for outreach staff to encounter unsheltered families with minor children or for CoC staff to receive reports of such families from concerned citizens. Since the pandemic, and especially since the lifting of the eviction moratorium, CoC staff have received a significant increase in calls regarding unsheltered families. Often these turn out to be families who are living in hotels and pan-handling to make ends meet, however reports of families living in cars has also been increasing. Currently our CoC has no services with experience or focus on serving unsheltered families. While there are many similarities and challenges for the sheltered and unsheltered homeless in our community the street outreach staff and people with lived experience consistently identify these common barriers which are most significant for people who are unsheltered:

`Planning Process

NC-500 has reviewed both the HUD and general literature on the causes and solutions to homelessness and in particular, street homelessness prior to developing this plan. This information was shared across the full membership of our CoC. This background helped to inform our process with the recognized best practices for addressing unsheltered homelessness. In order to craft a plan that would best serve this community, the CoC designed an inclusive planning process which facilitated meaningful opportunities for input from a diverse array of stakeholders. Over the course of six weeks, multiple opportunities were provided to homeless service providers, mainstream service providers, developers, landlords, community members, elected officials, and people with lived experience of homelessness including those who are formerly and currently homeless to provide input into the development of this plan on how to retool the homeless service system to better meet the needs of the unsheltered population prior to it being presented to the formal governance body of the CoC for approval.

A particular focus was place on how people with lived experience were included in the conversation about the plan. While it is standard practice within the CoC to included representatives of people with lived experience in planning meetings, we wanted to provide the opportunity for a wide cross section of people with lived experience to participate in the planning. In order to ensure meaningful participation in the plan development for people with lived experience of homelessness in our community, and in particular those who are currently unsheltered, multiple opportunities and strategies were employed to receive input to the plan. This included surveying people through coordinated assessment interviews, attending the Homeless Caucus meeting to engage in conversation about the plan, and encouraging street outreach staff to collect input from the people they engage with.

Stakeholder Interest

As the Collaborative Applicant the City of Winston-Salem solicited letters of Intent (LOI) from prospective project applicants to determine additional needs the community may have in providing services. These LOI provided insight into the community's capacity and various organizations interest in providing an array of services that will focus on the needs of the unsheltered population. The LOIs assisted with conversations at the round table meetings to have discussions around needed services and creative ideas to implement programs to provide these services.

Current Landscape of Housing and Services for the Unsheltered

Coordinated street outreach that identifies and engages people living in unsheltered locations play a critical role within the homeless system. Effective street outreach engages individuals who may not otherwise reach out for homeless services and works to meet the basic needs for those who are unsheltered. NC500's investment in services to people who are unsheltered has not increase significantly since before the pandemic when people who were unsheltered represented 10-14% of the population. Within the geographic footprint of the CoC there are three homeless service organizations who provide targeted services to people who are unsheltered, including:

- The Bethesda Center receives funding for one case manager who engages in some street outreach, but primarily supports people who are unsheltered and utilizes their Day Center's drop-in services with services such as providing engagement, case management, basic needs supplies, and supportive services.

- City with Dwellings operates a peer-based street outreach service. Staff provides outreach to encampments and provides regular engagement with people at local day shelters and other frequently visited locations such as the public library. The street outreach team strives to provide engagement and ensure unsheltered homelessness individuals basic needs are met while supporting them towards housing stability.

- The Empowerment Team provides case management and peer support to people who are unsheltered. This Team has been run by Atrium Health/Wake Forest Baptist Hospital; however, the hospital has announced they are discontinuing this service sometime in the fall of 2022.

The three services mentioned above all work closely with the CoC's Community Intake Center to expedite access for people who are unsheltered to supportive housing resources. In addition, all street outreach staff help to connect individuals on the street to open shelter beds. Common concerns about current shelters, expressed by people who are currently unsheltered include, difficulties for people with certain mental illnesses to function in a mass shelter setting, lack of options for two adult households to be sheltered together, lack of options for sheltering with companion animals and lack of shelter for people who work evenings/nights.

In addition to these street outreach services there are numerous outreach efforts by local faith communities. These efforts primarily address basic needs such as food and clothing. There are often events being offered once a week or once a month. Most of these events do not offer connections to health or housing services.

Forsyth County, through the Emergency Medical Services (EMS) runs a special unit called Mobile Integrated Health (MIH). This team is responsible for managing the EMS "frequent flyers" many of whom are people who are both unsheltered and chronically homeless. The MIH team coordinates with the CoC and the street outreach providers to support individuals with connecting into homeless and mainstream services to address their health and housing needs.

The Community Intake Center (CIC), the CoC's coordinated assessment program maintains Outreach staff who are tasked with ensuring unsheltered individuals are connected to and able to access the full array of services within the CoC. They coordinate with the street outreach workers and accompany them at least once a week to connect with unsheltered people. In addition, the CIC hosts a weekly meeting for all services engaged with the unsheltered. In addition to the above-mentioned services, law enforcement also participates in this coordination of services. It is significant to note that while law enforcement does participate in the coordination meetings because they often have relationships with unsheltered individuals in the community, they do not see their role as a primary responder to homelessness nor do they use law enforcement to manage the homeless population. It is not that our community is without instances of arrests for activities related to being homeless, but law enforcement does not as a policy arrest people simply for being visible and homeless.

In the development of this plan the lack of street-based services, in particular the lack of a multidisciplinary team which can address health, mental health and substance use issues was cited as a significant problem. The alarm on the lack of an interdisciplinary street outreach team has been amplified with the impending loss of the Empowerment Team.

Barriers to Housing

While lack of services targeting people who are unsheltered is a part of the challenge our community faces in addressing the needs of the unsheltered, the lack of housing, and the lack of clear pathways to supportive housing for the unsheltered has been identified as additional challenges.

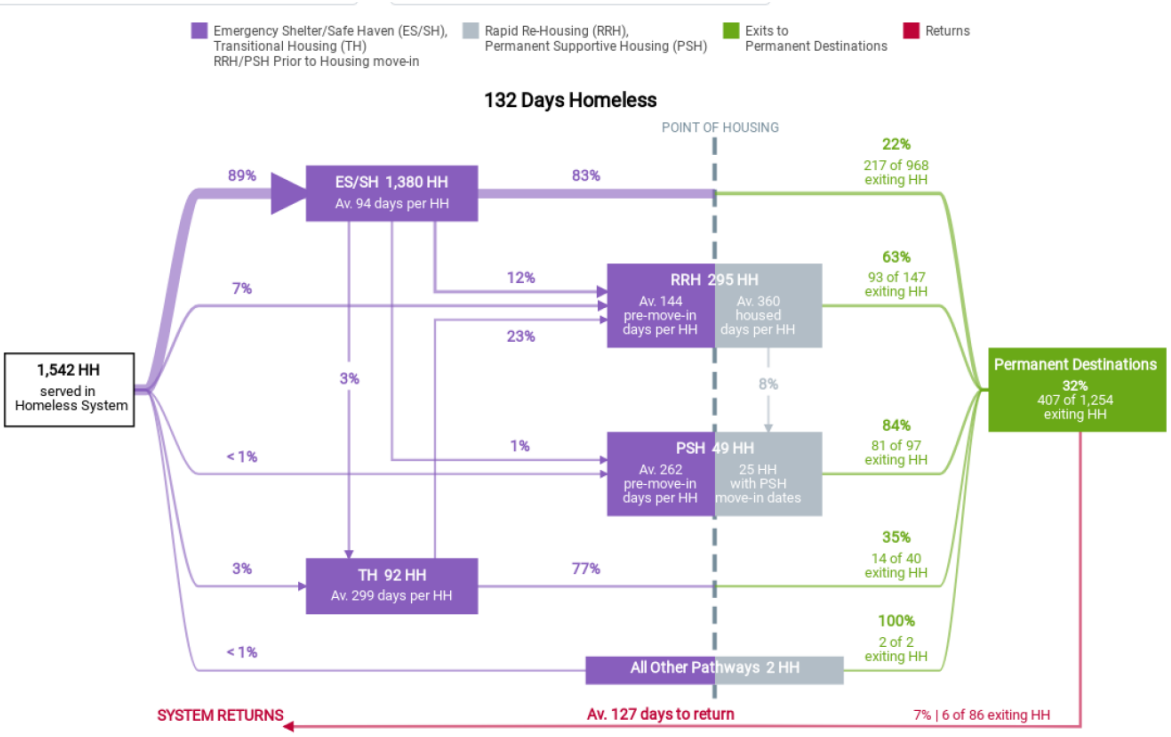
System wide the average length of time homeless is 132 days. This is up significantly from pre-pandemic when the systemwide average was less than 70 days. There are several contributing factors to this problem including a lack of housing inventory. In a recent housing study, the City of Winston-Salem identified it was 16,000 housing units short of the population need, and this lack impacts low-income communities more acutely. Related to the inventory shortfall is the challenge being faced since the lifting of the eviction moratorium, many properties that formerly accepted housing subsidies from either vouchers or rapid re-housing programs, are no longer willing to work with these programs. The most often cited reasons for this is they have tenants willing to pay substantially more for the units then the FMRs will allow, and who do not require inspections, recertifications or other processes. Because of these two factors combined

with the fact that the bulk of NC500's supportive housing inventory is in scattered site, voucher-based programs which rely on the private market accepting vouchers, the CoC is experiencing significantly long wait times for people to be able to identify units.

Currently the Winston-Salem/Forsyth County CoC utilizes landlord incentives to engage landlords to participate in the coordinated entry system. These landlord incentives allow landlords to receive double deposits as well as payment for repairs that are needed. However, even with landlord incentives, we still have trouble locating housing. A major barrier in locating housing is the extremely low FMR rates in the area. The FMR rates do not correlate with market rates which causes many landlords to not want to work with our programs. To increase landlord, buy in, the CoC is looking at strategies including retention of case managers who focus on landlord and client housing retention. These case managers will work as mediators and points of contact for landlords while also providing the needed wrap around services and resources to clients who have been housed through our various CoC programs.

SERVICE COORDINATION

When reviewing the pathways within our system to receive assistance, 89% of those who request assistance and receive assistance for Rapid Rehousing or Permanent Supportive housing comes from residing in emergency shelter. This figure demonstrates the gap in services for those who are unsheltered who currently represent 60% of the homeless population.



Ensuring people know how to connect to services and where to go for help is very important particularly for people who are unsheltered. The lack of consistent access to staff knowledgeable in navigating the homeless and mainstream service systems is a significant concern for people experiencing unsheltered homelessness as well as the limited street outreach staff.

The Winston-Salem/Forsyth County coordinated entry plan utilizes a no wrong door philosophy. This approach allows individuals to access coordination services through any homeless service provider- either street outreach or shelter. The goal of the no wrong door approach is to ensure individuals are receiving help by reaching out to any entity at anytime. It was significantly more effective pre-pandemic when 90% of the homeless population was connected to a shelter provider. With the shift to having 60% or more of our homeless population unsheltered the no wrong door has led to confusion and bottlenecks for people who are unsheltered.

United Way of Forsyth County, operates the Community Intake Center (CIC) the CoC's coordinated entry service. The CIC has a hotline number, available 7 days a week, where individuals can call and receive information about shelter, housing services, and help accessing either. The CIC staff also provide an entry assessment for supportive housing services. Because of COVID, these assessment appointments have been primarily virtual since March 2020. In March 2021 in person assessments started being offered upon request and are now offered weekly at the City with Dwelling Community First Center drop-in center.

NC500 has not previously invested in case management and supportive services for people who are unsheltered and waiting for supportive housing. Winston-Salem/Forsyth County CoC recognizes for our CoC to run effectively we must utilize community partners, state and local resources, and mainstream programs to prepare individuals for housing and services at the moment they request assistance. In order to be responsive in real time, the CoC needs to increase investment in multidisciplinary skilled staff working directly with people who are unsheltered, and ultimately who are skilled and equipped to help people move from being unsheltered directly into permanent housing.

The CIC has 1.5 FTE who provide the assessment for accessing coordinated services. This level of staffing was adequate when the bulk of the population was shelter based, and shelter staff were supporting data collection and assessments. Given the limited street outreach staff available in the CoC, the CIC's current capacity does not provide adequate access for people who are unsheltered.

Stakeholders have identified the need to increase the capacity for the CIC to connect with and serve the unsheltered population, and to expand their knowledge and ability to coordinate access to mainstream services for people who do not have other supportive services which can help facilitate that access.

An additional barrier related to the coordination of services that has been identified by providers as well as people who are unsheltered, is the challenge of accessing interdependent services which are spread across the community. Across all stakeholders, the desire to see the development of a multidisciplinary team that provides mobile services to the unsheltered as well as developing one stop service centers was a top priority for improving access to these services for the unsheltered.

Services Loss

The NC-500 CoC just like other CoC's has had difficulty maintaining organizations and staff during COVID-19. Until August of 2022, NC-500 partnered with Atrium Health to work with an outreach team, the Empowerment Project team. The Empowerment Project team has a focus on serving people with severe and persistent mental health disabilities and those who are chronically homeless with peer support and case management. Atrium Health has decided to discontinue this service to those experiencing unsheltered homelessness. The loss of services and staff will decrease the number of staff avaible to offer engagement to our most critical population. All stakeholders in the community agree the preservation of the Empowerment Project Team either at Atrium or another organization is a top priority.

Prior to the pandemic the level of street based services the CoC invested in was adequate to meet the needs of the unsheltered population. Now with the dramatic rise in the number of unsheltered people in our community coupled with the lingering impact of the pandemic on our shelter system, and the lack of affordable housing stock, this minimal level of service is no longer adequate to meet the needs in our community.

Community Identified Priorities:

Throughout conversations with all stakeholders' common themes emerged regarding needed services. They include the following:

Multi-Service Center:

An effective coordinated entry process is a viable component of ending homelessness. Coordinated entry systems should be in an accessible and centralized location for individuals who need assistance. Households should be able to easily access the system and coordinated staff should be available to identify and assess the needs of individuals who are in crisis. Our community in the past has lacked the resources needed to develop and meet all the needs of people who reach out for assistance causing barriers for individuals to access the system for instance having long wait times for assessments or to

receive assistance. To ensure our CIC promotes fair and equal access, NC-500 is proposing to open a multi-service center location which will house our Coordinated Intake Center and create a viable access point for assistance across the city. This center will be able to house case management staff, intake and assessment staff, and diversion staff to assist households who seek assistance.

People experiencing homelessness identified a lack of knowledge on how to access help within the system as a significant issue. NC-500 is planning to create marketing strategies to include informational flyers, advertisements on buses, updates to the CoC website, and the use of social media outlets. The goal is to improve understanding about how to access services and to improve the accessibility of these services to the public in a fair and equitable manner.

One common theme across stakeholders was the consistent need for people who are unsheltered to access a diverse set of mainstream services including health care, mental health care, substance abuse services, income supports, case management, and the challenges they have accessing services. The development of the multiservice center will provide a one-stop location for individuals who need assistance. There will be staff co-located from multiple service provider organizations to provide information and assistance with various programs including diversion assistance, emergency shelter, access to mainstream benefits, and behavioral services. The site coordinator would work with street outreach service providers and with people with lived experience of unsheltered homelessness to prioritize locations and what services are highlighted at these locations.

Long wait times make a homeless assistance system less effective and effects the performance and service delivery for a CoC. The goal is for initial assessment of households and individuals to happen as quickly as possible regardless of where households are residing. To accomplish this, diverse stakeholders must have a different role in the coordinated entry process. Homeless assistance agencies should be involved in the coordinated entry process by helping households access the system and accepting referrals. Homeless assistance agencies will also provide space to conduct assessments as needed. Affordable housing and mainstream service providers are critical to the coordinated entry system. As we strengthen our coordinated entry system, mainstream providers can be co-located at the multi-service center as well. The more mainstream programs onsite would bring stronger relationships with behavioral health, substance abuse, and social service workers. As relationships strengthen the CoC can effectively and consistently connect more homeless individuals with housing resources and the community-based support needed to maintain housing and locate homeless assistance services.

Multi-disciplinary Street Outreach:

With the rise in the number of unsheltered people in our community coupled with the lingering impact of the pandemic on our shelter system, the lack of affordable housing stock, the level of service provided through street outreach needs to increase. Unsheltered homeless individuals are repeated users of emergency services, especially medical and law enforcement services. The use of a multidisciplinary team will allow street outreach teams to provide health care and other support services while locating and obtaining housing in the process of addressing other needs. The street outreach teams in our community are currently funded through various government programs and is not funded at levels that would allow for a full implementation of activities and approaches that would benefit our community. NC 500 is motivated to increase the role our street outreach programs play within our system. By increasing the role of the street outreach teams, we hope this will make our system more effective for those who are living unsheltered, by helping them to return to affordable and safe permanent housing. A multi-disciplinary approach is needed to improve the street outreach services we provide to those we serve.

The goal of the street outreach team will be to make connections to stable housing with services needed to assist the client to sustain their housing for long terms. Services such as health and behavioral health care, transportation, and information about mainstream benefits is needed for a client to sustain housing. With a multi-disciplinary approach critical services can be provided through various stakeholders. Critical services may include peer support, case management, mental health services, harm reduction focused substance abuse services, and medical care coordination through mobile integrated health, an embedded nurse practitioner, or other health care coordinator. Providing these services where the unsheltered reside reduces the barriers to accessing these services. The goal of the multi-disciplinary team is to coordinate with a broad network of programs and staff who are likely to encounter the unsheltered homeless population. Examples may include law enforcement, first responders, hospitals, behavioral health providers, child welfare agencies, faith-based organizations, and other community-based providers.

Increase Project Based Housing Options:

The City of Winston-Salem, like many other places, lacks the amount of affordable housing needed to meet the needs of the community. Overcoming barriers to create more housing at affordable and market rate levels is a critical step in reducing homelessness in the Winston-Salem area. According to a comprehensive 2018 study, commissioned to better understand the state of housing affordability in our community, fewer than half of all rental units in Winston-Salem are affordable to families earning 80% of AMI or less. This has resulted in a shortage of more than 16,000 affordable homes. Households within Winston-Salem/ Forsyth County occasionally pay more than one third of their annual income toward housing and are considered cost burdened. Winston-Salem Forsyth County is cited in HUD's "FMR Area Determined to Have Significant Rental Market Fluctuations". Our current PHA payment standards are also low, making it hard to house individuals even with a housing choice voucher. Winston-Salem Forsyth County is cited in HUD's "FMR Area Determined to Have Significant Rental Market Fluctuations."

To address the needs of housing, the Winston-Salem/ Forsyth County CoC plans to utilize alternative housing models to increase the accessibility of local housing options. The City of Winston-Salem plans to work closely with the local Housing Authority, HAWS, to locate ways to increase the utilization of vouchers. With the low FMR rents it has become a barrier to obtain housing using regular Housing Choice Vouchers (HCV) . The Winston-Salem/ Forsyth County CoC is looking to partner landlord incentives with vouchers to assist with paying for holding fees, double deposits, and repairs for units prioritized to those experiencing homelessness. The Winston-Salem/Forsyth County CoC will also work to partner with HAWS to utilize permanent supportive housing funds for dedicated set aside units within their market rate housing projects. With set aside units being available for use for those who are unsheltered, the amount of affordable housing supply available to those we serve will increase.

The Winston-Salem/ Forsyth County CoC also understands the importance of landlord engagement. The CoC will take part in extensive landlord engagement procedures to gain additional landlords who are willing to work with our programs and to retain landlords who currently work with our programs. Landlord incentives will also be made available for landlords who rent to clients experiencing homelessness. These funds will be prioritized for those who are experiencing unsheltered homelessness. Landlords play an essential role in providing housing resources to those we serve and creating partnerships with private market landlords is critical in moving people into housing. The Winston-Salem Forsyth County CoC will also provide landlord incentives to assist with repairs and holding deposits for those we serve.

Healthcare Housing:

Winston-Salem/Forsyth County CoC is looking to partner with community health partners and housing agencies to leverage mainstream housing and healthcare resources. Winston-Salem/Forsyth County CoC understands poor health is a major cause of homelessness. Housing alone will not solve the problems of people experiencing homelessness and healthcare must be part of the solution too. Recognition of the special health care needs of homeless people has encouraged Winston-Salem/Forsyth County CoC to focus on housing dedicated to these services. Housing and health care work best together and are essential to preventing and ending homelessness. Health care services are more effective when a patient is stably housed, and in turn, maintaining housing is more likely if proper health care services are delivered.

Pathways to Healthy Housing is a permanent supportive housing program that is a partnership between the Winston-Salem/Forsyth County CoC, as represented by the United Way of Forsyth County, and United Health Centers, our local Federal Qualified Health Center. The goal of this project is to support people experiencing chronic homelessness and chronic health conditions obtain and maintain permanent housing as a critical component of improving their health outcomes. Chronically homeless people experience substantially higher morbidity in physical and mental health, as well as increased mortality. The traumas many experience while on the streets or in shelters has

been demonstrated to have long-standing adverse impacts on psychological wellbeing. These and other challenges related to the experience of homelessness can result in persistently high health care expenditures due to emergency department and inpatient hospital use. By providing permanent housing with supportive services including health care and case management focused on connecting individuals to community and mainstream support, this project will improve individuals housing stability, income, and health outcomes.

The Pathways to Healthy Housing project will work with the CIC
, to identify individuals with co-occurring health and mental health co-morbidities who have been homeless for longer than 12 months and help them identify safe, healthy, affordable housing. In addition, the CIC staff will conduct warm referrals to the United Health Centers for Case Management and Primary Care. On at least an annual basis, CIC staff will follow-up with program participants to assess ongoing housing stability needs.

The United Health Centers' case manager will work with the program participants to develop a housing stability and health care plan, including individualized goals. Program participants will be supported by the case manager in completing applications for housing vouchers and mainstream services such as SNAP and SSI/SSDI, accessing local food and nutritional programs, and connecting to vocational services or vocational rehabilitation services as appropriate to their health conditions and other community-based services which aid the program participant in achieving their housing and health care goals.

The case manager will meet with the program participants at least monthly or more frequently based on individual needs and desires to evaluate progress on their housing and health goals. During these meetings, the case manager will provide guidance, support and education to help program participants overcome barriers to their housing and health goals.

Winston-Salem/Forsyth County CoC will also partner with other local healthcare providers to provide outreach health care services to those who are currently unsheltered. Currently a mobile health bus is stationed at a local soup kitchen and emergency shelter, available to provide preventative care services to those who are experiencing homelessness.

Overall, the Winston-Salem/Forsyth County CoC and other stakeholders are set to work collaboratively to house our unsheltered residents. With additional resources and community support, we believe that we can work collaboratively to provide housing and other needed supportive services and resources to the unsheltered homeless population. The Winston-Salem/ Forsyth County CoC has identified priorities that we believe we aid us in working with the unsheltered population to move them into safe and affordable permanent housing. The identified priorities we have mentioned will not only increase the housing placements for our CoC but will also increase the accessibility and delivery of services to those who are hard to serve. To ensure that this plan works the Winston-Salem Forsyth County CoC will utilize HMIS data and client participant feedback to study if the needs of the unsheltered population is being met. The Winston-Salem/Forsyth

County Continuum of Care is dedicated to ensuring that people in our community who are experiencing homelessness return to housing as quickly as and do not experience further housing crises. Our (CoC) is committed to ending possible homelessness for all people who are experiencing a housing crisis within the community. This means ensuring that those who are unsheltered or living in emergency situations return to housing as quickly and efficiently as possible. This plan is designed to articulate a path to achieve these goals by utilizing strategies to improve our existing homeless response system.

Diversity, Equity, and Inclusion

Ensuringthe homeless service system provides the highest and best quality of services to people in our community experiencing homelessness is a critical concern of the CoC. As a part of the CoC's commitment to providing services, it is committed to a system-wide process of evaluation of racial disparities between the homeless population and the overall population as well as disparities in access to services and outcomes. Over the last year the CoC has identified a list of actions related to improving diversity, equity and inclusion and ameliorating the impact of racism. New partners who accept funding from the CoC will be expected to participate in this work with the CoC including self-evaluation and reflection, reviewing local policies, procedures, and processes to determine where and how to address disparities affecting underserved communities experiencing homelessness and identifying and implementing strategies for improvement towards the vision of having a racially just system of care.

Trauma Informed System

The impacts of trauma and chronic stress are significant for people experiencing homelessness and for the people and organizations serving them. A significant body of research has documented the adverse impact of trauma on people's development, cognitive development, and health. For people experiencing homelessness the prolonged experience of the trauma and chronic stress associated with being homeless can overstimulate their autonomic nervous system leaving them stuck in survival mode, making it difficult for them to process information and make plans. In turn, without training and education, homeless service staff can perceive this response to trauma as being uncooperative or service resistant. In addition, the impact of serving people who are living with constant trauma and chronic stress has also been documented to have profound effects on the service providers and their organizations, often leading to high turnover and toxic work environments.

An additional layer to the impact of trauma on the homeless service system is the role of racial trauma in our community. A simple look at who becomes homeless in our community provides a glimpse into the impact racism has on people experiencing homelessness. In Winston-Salem/Forsyth County, roughly 70% of the population is white and 30% African American. Of people who experience homelessness, the ration is reversed, 70% of the homeless population is African American, and about 30% is white. This disparity derived from a system of housing that intentionally disinvested and discriminated against African Americans. The scars of this trauma

is literally outlined by a highway in our community segregating historically African American neighborhoods from white ones. This divide continues to mark the disparities in access to housing, education, employment, health care and economic mobility. By investing in the work to become trauma informed, we as a system will be investing in strategies to address the harms caused by these injuries.

Recognizing the profound impact that trauma has on our community, on the people we seek to serve and the people we employ to provide services, the Winston-Salem/Forsyth County CoC has committed to become a trauma informed homeless service system. We have partnered with the Center for Trauma Resilient Communities to implement a CoC-wide strategy for addressing the impact of trauma on the lives of people in our system—both clients and staff. As a part of this commitment the CoC will be providing training to all personnel in homeless service organizations as well as support for the boards and management of these organizations for implementing trauma informed policies and practices. Our goals include improved quality of care, better outcomes from service interventions, as well as reduced staff turnover, and improved health outcomes for both people experiencing homelessness and the staff who serve them.

We see this work as particularly critical for those service providers who are working with the unsheltered population.

A significant part of the work to become a trauma informed system is learning how to build and nurture resilience both for individuals and organizations. The protective powers of resilience are rooted in building and sustaining positive relationships and community. As such new services/organizations will be welcomed into the CoC's work to become a trauma informed system and will be expected to participate in the learnings, self-reflections and improvement work related to become trauma informed and resilient.

Conclusion

After an intensive planning process the CoC's plan for improving services to our growing unsheltered population is housing focused and human centered. It will focus on improving access to permanent housing and the key health and human services necessary to help people achieve housing stability. Priorities include:

1) Improvements to the coordinated assessment system, including expanded capacity for assessment and coordination, as well as an evaluation of the no-wrong door strategy to improve clarity as to what is the right door to access for people who are unsheltered.
2) Increased capacity for street-based services, including the preservation of the Empowerment Project team which serves people with severe and persistent mental illness, as well as the addition of a multi-disciplinary team who can serve a population with significant co- and tri-morbidities.
3) Development of a one-stop service center where people who are unsheltered can access critical services including case management, coordinated assessment, supportive housing, health care, mental health care and physical health care.
4) Expansion of project based permanent supportive housing options.

In addition, the services that will be funded to meet these priorities shall work with the CoC on its' racial equity improvement strategies as well as participate in the work necessary to create a trauma informed system and organizations within the homeless service system.

Of significance note, absent from the plan is a call for more shelter or transitional housing. While there is certainly a call for improved access to the current shelter system, the emphasis from all stakeholders was on expediting the process and expanding the pathways to permanent housing from the streets. This is consistent with the CoC's housing first philosophy—which emphasize and prioritized rapid access to permanent housing for people experiencing homelessness.

The CoC during this process has also prioritized project based supportive housing options. While we will continue to work with our local housing authority and private landlords, it is clear that investing in permanent housing infrastructure dedicated to housing people who have formerly been homeless is critical to achieve the long term goals of the CoC for homelessness to become rare, brief and non-recurring.