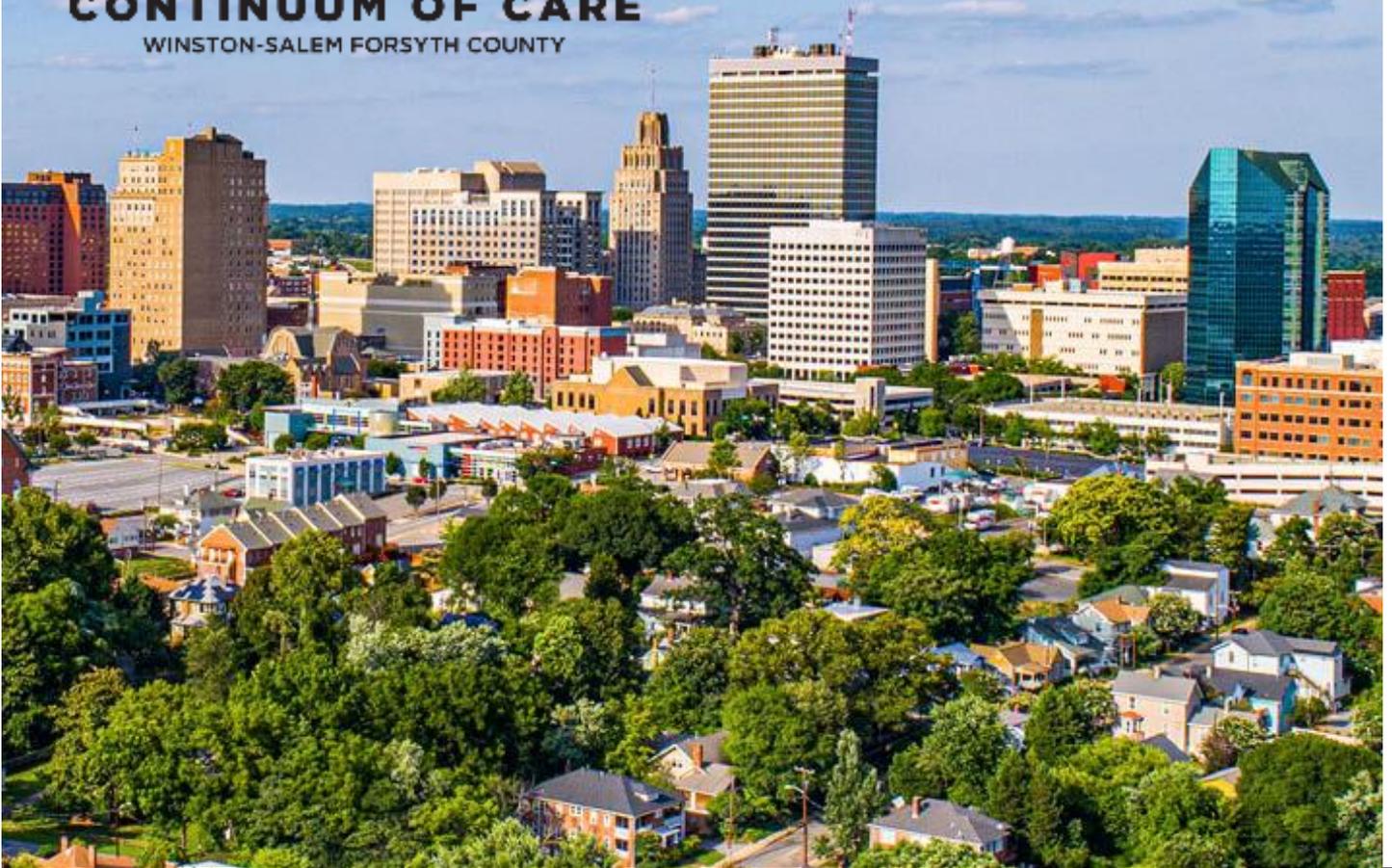




**CONTINUUM OF CARE**  
WINSTON-SALEM FORSYTH COUNTY



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

## Background

Despite Winston-Salem/Forsyth County Continuum of Care’s progress to create a housing system that rapidly houses individuals and assists many with basic needs and services each year, the homelessness crisis continues to grow. The systemic factors driving homelessness in our community range from the shortage of staff to an extreme lack of housing options that are affordable to residents, these factors are continuing to push more of our neighbors onto the streets every day. These challenges partnered with the coronavirus (COVID-19) pandemic mean the need to address and create a plan to effectively assist the unsheltered population is essential. This public health crisis has required a massive and immediate response by our crisis response system to quickly ramp up shelter capacity, increase access to hygiene services for people living outside, and protect those people experiencing homelessness who are particularly vulnerable. As a result, as this plan goes into effect, we anticipate there will be many more people experiencing or at risk of unsheltered homelessness who will need immediate support, which will require our community to continue to be flexible and innovative in our responses to homelessness.

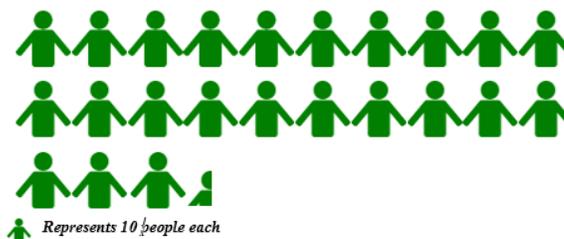
Even before the COVID-19 pandemic placed a strain on the homeless assistance system and increased the number of unsheltered homeless people within the community, the street homeless population was a growing concern and key population in need of assistance for the Winston-Salem/Forsyth County Continuum of Care. Between March 2020 and August 2022, 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 45% of people experiencing literal homelessness on any given night in our community. Pre-pandemic this population represented 10-15% of the overall homeless population.

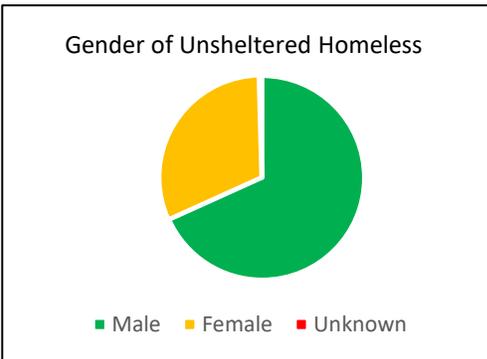
Over the last 60 days the Winston-Salem/Forsyth County CoC has engaged in intensive planning to develop a plan to address this shift in need and re-tool our homeless service system to better meet the needs of people who are unsheltered. To address this growing, need the CoC has developed this service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

## Snapshot of Unsheltered Homelessness in Winston-Salem/Forsyth County

The Winston-Salem Forsyth County By Name lists currently has more than 223 individuals listed as unsheltered- sleeping outside in vehicles, tents, or other places not meant for habitation. The rise in affordable rent costs, loss of employment, and shortage of staff could be factors to contribute to the rise in the current numbers of those experiencing unsheltered homelessness. Families with children, seniors, individuals with disabilities, veterans, youth, and young adults are all represented in this population.

- The current number of known unsheltered individuals in Winston-Salem, Forsyth County is 233 (as of August 15<sup>th</sup>, 2022).





- The current unsheltered population is twice the size of the current sheltered population.

- 68% of unsheltered individuals are men and 31% of unsheltered individuals are women.

- 11 (4%) of unsheltered individuals are identified as veterans.

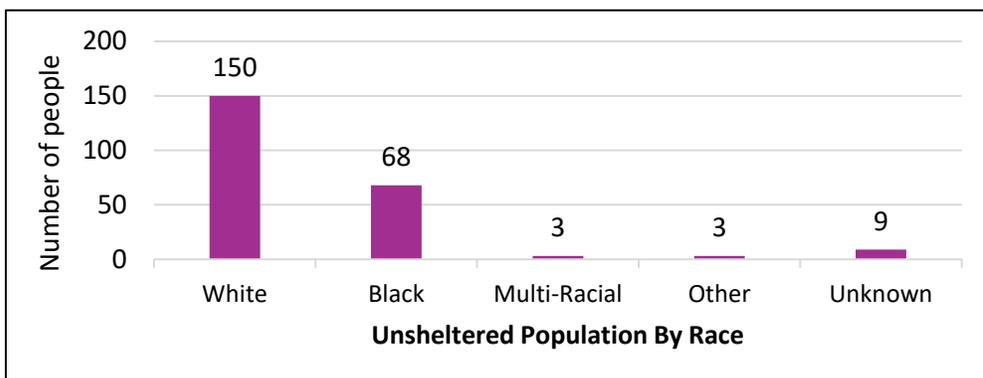
- Over 50% have a mental illness, and almost 25% have a confirmed substance abuse disorder.

- Majority of the unsheltered population identifies as white. Majority of the population that utilizes the shelter system identifies as black.

- Currently, 89% of the people served by our CoC use the shelter system at some point. We are striving to strengthen the pathways to CoC services for those who do not use shelter.

- Unsheltered families are unrepresented in this data. The sightings of unsheltered families have increased since the start of the pandemic.

- Data collection and data quality capacity needs to improve to better understand the unsheltered population and provide better services in the future.



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:

**Challenges of unsheltered homelessness**

SHELTER SPACE	OTHER BARRIERS	HEALTH & SAFETY
<ul style="list-style-type: none"> <li>o No available shelter space for those with severe mental issues or substance use disorders</li> <li>o Limited space for respite, palliative, or hospice care</li> <li>o Limited shelter space for those with disabilities</li> <li>o No shelter space for pets</li> <li>o Lack of shelter for caregivers (where person needing care is different gender)</li> </ul>	<ul style="list-style-type: none"> <li>o No storage options</li> <li>o Limited daytime options to form healthy community</li> <li>o Limited daytime options to stay out of weather</li> <li>o Limited employment options</li> <li>o Limited low-barrier access to services</li> <li>o Income disparities</li> <li>o Lack of affordable housing!</li> </ul>	<ul style="list-style-type: none"> <li>o Trauma is almost universal</li> <li>o Tri-morbidity (physical health condition + mental health issue + substance use disorder)</li> <li>o Struggle to meet basic needs</li> <li>o Struggle to maintain housing without support, which is limited</li> <li>o Opioid crisis</li> </ul>

2022 Unsheltered homelessness

### Planning Summary

NC500 is committed in all its planning efforts to provide meaningful opportunities for a diverse array of stakeholders to participate in the planning process. Our commitment is to include homeless service providers, mainstream service providers, developers, property owners, community members, elected officials, and people with lived experience of homelessness, including those who are formerly and currently homeless, in the development and execution of the unsheltered plan.

Over the course of six weeks the Winston-Salem/Forsyth County Continuum of Care engaged multiple stakeholders in conversations focused on how to retool the homeless service system to better meet the needs of the unsheltered population. The CoC held round table meetings which included representatives from a wide variety of stakeholders. To truly end homelessness in Forsyth County, we must collaboratively work together to provide and allocate resources to not only respond to the current crisis but to also create successful housing strategies and eliminate the root causes of homelessness in our community.

### Involving Persons with Lived Experience

The Winston-Salem/Forsyth County CoC emphasized the importance of involving persons with lived experience in the planning and evaluation of applications. The CoC works to involve persons with lived experience in every aspect of the CoC process including having individuals

serve on the Rating Panel to review funding applications. Staff collaborated closely with persons with lived experience and the Homeless Caucus to ensure they were included in the conversation and implementation of the unsheltered plan. To engage participation for people with lived experience, and in particular those who are currently unsheltered, multiple opportunities and strategies were employed to receive feedback about the design of the unsheltered plan. This included surveying people through coordinated assessment interviews, attending the Homeless Caucus meeting to engage in conversation about the plan and how it should be implemented, and encouraging street outreach staff to collect input from the people they engage. Many individuals shared their ideas and experiences about experiencing homelessness and living unsheltered and ideas were shared about how to improve local homeless services. Ideas ranged from more access to personal hygiene items to a large homeless community hub where access to homeless services would be in one location.

### **Overview of Current Services**

Street Outreach- 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 seek homeless services and works to meet the basic needs for those who are unsheltered. Currently the Winston-Salem/ Forsyth County CoC provides street outreach services through two organizations. The street outreach staff within the CoC provides engagement, case management, basic needs, and supportive services to those they locate sleeping in unsheltered locations. At this time, the street outreach teams work to engage unsheltered individuals by providing ongoing referrals and resources for emergency shelter, as well as other available assistance within the Continuum of Care, such as resources for food, showers, and case management services. Staff provides outreach to encampments and provides regular engagement with individuals at local day shelters and other frequently visited locations such as the public library. The street outreach team strives to provide engagement and ensure that unsheltered homeless individuals basic needs are met while supporting them towards housing stability. The street outreach team works collaboratively with the CoC's Community Intake Center to expedite access for people who are unsheltered to supportive housing resources including emergency shelter. Locally, faith communities are also apart of the street outreach efforts to the unsheltered population. These local faith communities primarily address basic needs such as food and clothing. There are often events held during the month that offer these basic need services.

The Community Intake Center (CIC), the CoC's coordinated assessment program and outreach staff, are tasked with ensuring unsheltered individuals are connected to and able to access the full array of services within the CoC such as emergency shelter beds and case management. Each week the street outreach workers meet to connect and discuss the coordination of services with unsheltered individuals. Law enforcement also participates in the coordination of outreach services. A community officer collaborates with the street outreach team to locate encampments and individuals they frequently engage who may need homeless 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 and are known to have frequent visits to the emergency room. 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.

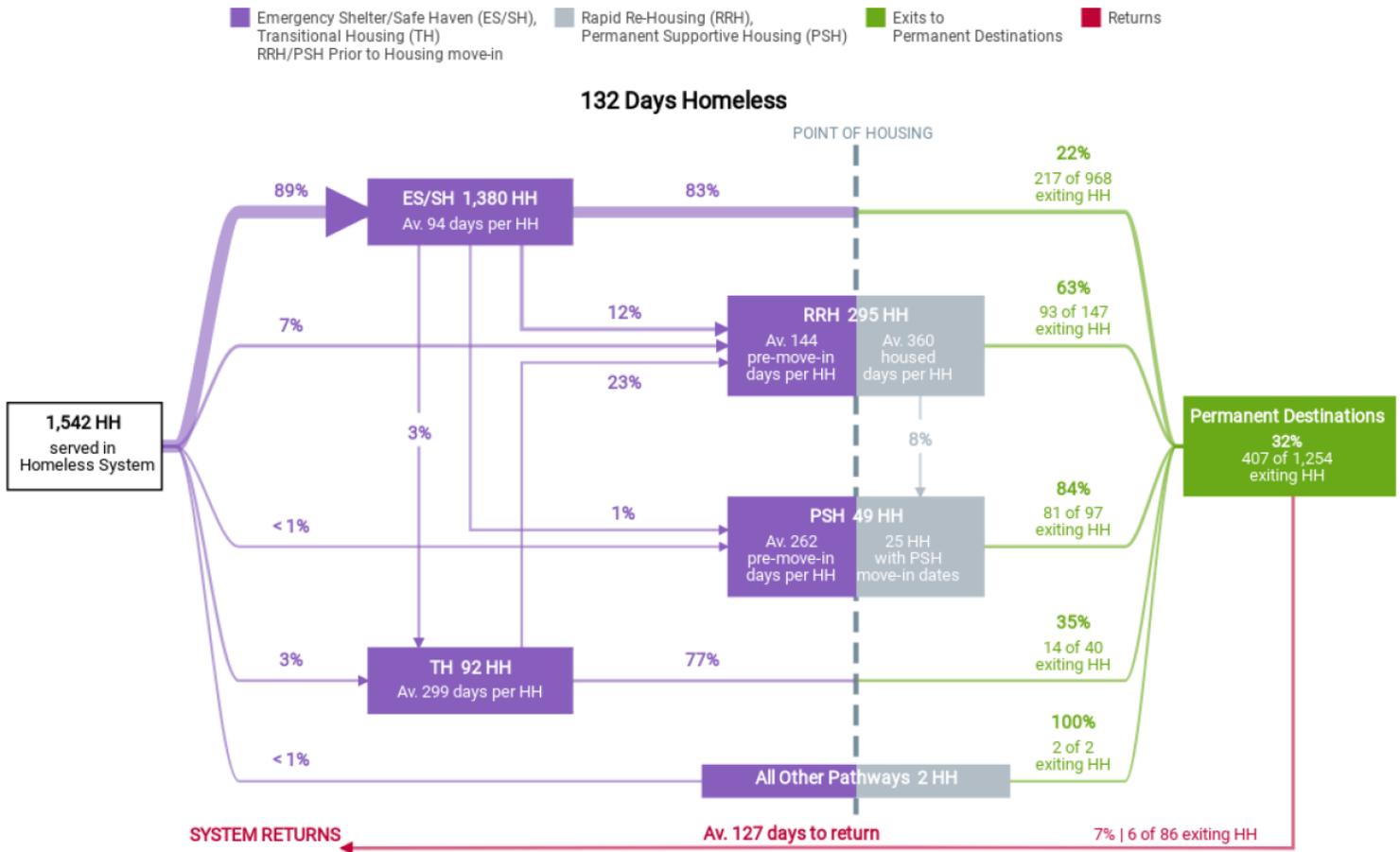
The Winston-Salem/Forsyth County CoC, just like other CoC's has had difficulty maintaining organizations and staff during COVID-19. Until August of 2022, the Winston-Salem/Forsyth County CoC partnered with a local health provider to provide street outreach. This street outreach team had a focus on serving people with severe and persistent disabilities and those who were chronically homeless. This team however could no longer be managed under the health provider and was no longer able to provide services to those experiencing unsheltered homelessness. The loss of these services and staff has decreased the number of staff available to offer engagement to our most critical population. With the rise in the number of unsheltered individuals in our community and the lack of affordable housing stock, our community recognizes there is a need for more staffing in street outreach to meet the needs of those we serve.

#### Coordinated Intake Center:

Ensuring people know how to connect to services is essential for the coordination and management of coordinated entry. Currently the Winston-Salem/Forsyth County CoC utilizes a no wrong door approach method to accessing services. This no wrong door approach allows individuals to access services through any service provider. The goal of the no wrong door approach is to ensure that individuals are receiving help by reaching out to any entity at any time. The Coordinated Intake Center (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 provides entry assessments for supportive housing services. When an assessment appointment is made the assessments are currently completed over the phone and in person assessments are completed upon request. Currently there is no case management and supportive services offered during the time individuals wait for housing assistance. 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.

The Winston-Salem/Forsyth County coordinated entry 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 any time. Unfortunately experience has shown that this no wrong door approach has not been effective due to the lack of accessible in person staff and services, and the lack of public information provided about services. People experiencing homelessness identified a lack of knowledge in the community on how to access help within the homeless system as a significant issue. Currently our Coordinated Intake Center lacks accessibility and does not meet the needs of the population we serve. Our CoC must increase the knowledge of the services offered through the CoC and the location of where services are available in order to reach those who may not usually seek assistance. We must also make our services accessible by providing in person assistance without the need for a request. Data confirms the lack of accessibility. 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 come from residing in emergency shelter. This figure recognizes a gap in services being available for those who are unsheltered and who do not enter through the shelter system. The Winston-Salem Forsyth County CoC recognizes this gap in providing services and plans to utilize data and funds through the Special NOFO to close this gap.



Data shows the lack of accessibility our current system has. 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.

Emergency Shelter:

Emergency shelters within the Winston-Salem/Forsyth County CoC are required to work within a low barrier and Housing First approach when providing emergency shelter services. Currently our local CoC does not have any non-congregate shelter available. The lack of non-congregate shelter options contributes to the high number of individuals who remain unsheltered. Over the last three years local emergency shelters have worked to become and remain low barrier. Each emergency shelters policies and procedures and shelter guidelines are reviewed annually, and assessment procedures are reviewed to determine if a low barrier approach is being utilized in

service delivery. Changes were made to shelters that did not meet the low barrier and trauma informed requirements. Ongoing trainings are also provided and are required for all participants in the Continuum of Care. The National Alliance to End Homelessness provided a six week training to cover low barrier emergency shelter and equal access to also enhance the understanding and requirements of managing a low barrier shelter. The Winston-Salem/ Forsyth County CoC understands the needs to locate permanent supportive housing and non-congregate shelter options within our CoC to serve those with high service needs. When discussing the plan with persons with lived experience, the lack of non-congregate shelter was a concern and reason many choose not to enter emergency shelter.

#### Landlord Engagement:

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 signing bonuses equal up to 2 months of rent, security deposits equal up to 3 months of rent, the cost to repair damages incurred by the program participant not covered by the security deposit and paying the costs of extra cleaning or maintenance of a program participants unit or appliances. These landlord incentives are provided in an amount that cannot exceed three times the rent charged for the unit.

The Winston-Salem/ Forsyth County CoC also understands the importance of landlord engagement. Our CoC and the City of Winston-Salem's Human Relations Department have taken part in the Landlord Engagement Lab, a program aimed to help small to mid-size cities prevent evictions and support community members by developing and refining their strategies for engaging with mom and pop landlords. The goal of this cohort is to help the CoC operationalize racial equity in a landlord engagement strategy, facilitate and strengthen relationships with mom and pop landlords, and develop policies, programs, and resources to support small landlords and prevent evictions. With this program the CoC is becoming better equipped to foster housing stability and find ways to connect and support our local landlords. The CoC also collaborates with the City's Human Relations Department on an Eviction Diversion group. This group was created in an effort to assist both landlords and tenants with alternatives to eviction. The group consists of housing professionals including property managers, owners, the Realtors Association, nonprofit agencies, government agencies and local community members. Despite participating in the local Eviction Diversion group and providing landlord incentives, many landlords are reluctant to work with our rental assistance programs. Many landlords state the amount of money allowable for units is too low and they have concerns about clients behavior after they are housed. The CoC continuously works with our landlords to strengthen relationships, however many of them show little interest in accepting rental assistance or Housing Choice vouchers at this time.

#### Permanent Housing: Permanent Supportive Housing & Rapid Rehousing:

The HUD and homeless research community has provided broad knowledge on what causes a household to experience homelessness and the services needed to house households rapidly and successfully. NC-500 understands the effects the housing market and available resources has on length of time a household is homeless. WSFC CoC plans to create a plan that recognizes the

housing market barriers and the lack of available and accessible homelessness assistance resources within the system.

Overcoming barriers to create more housing at both 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. Many households within Winston-Salem/ Forsyth County frequently pay more than one third of their annual income toward housing and are considered cost burdened. Our current PHA payment standards also are low, making it hard to house individuals even with a housing choice voucher. Winston-Salem Forsyth County is cited in the HUD Fair Market Rate (FMR) Area Determined to Have Significant Rental Market Fluctuations. In this study HUD identified areas with significant rental market inflations, where an increase in Public Housing Administration (PHA) payment standards up to 120 percent of the FMR may help the community more quickly house individuals. This study shows that HUD recognizes the lack of affordable housing that is available for use in our local CoC.

Currently, the Continuum of Care works with Emergency Solutions Grant funds, Continuum of Care funds, HOPWA, Housing Choice vouchers, and HOME-ARP funds to locate permanent and permanent supportive housing. Currently the CoC is experiencing difficulty locating units that are affordable for federal funds. The extreme high FMR rates compared to the local market rates makes it difficult to place clients into permanent housing even with a Housing Choice voucher or other assistance. As previously mentioned, the CoC currently uses landlord incentives and “sweat equity” to obtain units that can be utilized for rental assistance however this still leaves a gap in available units for those that we serve.

## **Our Plan**

### Strategy #1: Create a Multi- Disciplinary Street Outreach Team

With the rise in the number of unsheltered people in our community, coupled with the lack of affordable housing, the level and amount of engagement services provided through street outreach needs to improve. 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 goal of the street outreach team will be to make referrals and connections to emergency and stable housing while also providing services such as basic needs, case management, life skills, employment and other services that may be needed to assist clients in sustaining long term 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, life skills, job training and education referrals, and medical care coordination through mobile integrated health, an embedded nurse

practitioner, or other health care coordinator. Providing these services where the unsheltered population resides 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 daily. The goal is for the multi-disciplinary team to include law enforcement, first responders, hospitals, behavioral health providers, child welfare agencies, faith-based organizations, and other community-based providers who can assist with preparing individuals for permanent housing. Mental health providers embedded into the street outreach team are an essential link between inpatient and outpatient care for highly vulnerable street homeless individuals.

The street outreach team will have staff who provide engagement services each day of the week and after hours. The Coordinated Intake Center will receive calls about encampments and coordinate with the street outreach team to send street outreach staff to provide services and referrals to assist individuals with obtaining safe alternatives to sleeping outside and housing resources. The street outreach team will refer households to permanent supportive housing and rapid rehousing resources to assist with rapidly housing households as soon as they are identified. Referrals will be made to emergency housing options, permanent housing options and other needed supportive services. This multi-disciplinary street outreach teams' goal will be to successfully work with and house people directly from the street. The street outreach team will also hire people with lived experience. When an individual is engaged on the streets, the street outreach team should work with the individual to access emergency housing, assist with basic needs, and refer the individual for the appropriate housing resource needed for the client to obtain housing.

### Strategy #2: Create a Multi-Service One Stop 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 meet the needs of people who reach out for assistance, causing barriers for individuals who seek to access the system. For instance, our system has long wait times for assessments or wait times to receive financial assistance despite funds being available. To ensure our CIC promotes fair and equal access, the Winston-Salem/ Forsyth County CoC proposes to open a multi-service center location which will house our Coordinated Intake Center staff and create a viable access point for homeless assistance across the city. This center will be able to co locate case management staff, intake and assessment staff, and diversion staff to assist households who seek assistance. These on site CIC staff will provide in person triage, assessments, and referrals and resources for housing and supportive services. The multi-service one stop center will be in an accessible location that is near public transportation. On-site staff will be available Monday-Friday with limited weekend hours. The role of the CIC staff will be to act as the front line of the CIC and to provide engagement, referrals, and support until individuals are assigned to a case manager. Individuals with lived experience will also be hired to provide support to the CIC Team.

One common theme across stakeholders was the consistent difficulty people who are unsheltered have accessing a diverse set of mainstream services including health care, mental health care, substance abuse services, income supports, and case management. Many of these services are scattered throughout the City and the County causing barriers for accessibility. The development of the multiservice center will provide a one-stop location for individuals who need assistance. The multi service center will have spaces for co- located staff to use to provide case management and intake services to those who are experiencing homelessness. Shelter providers can also provide intake staff to conduct intakes onsite as shelter beds become available. Having 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 will allow services to be easily accessible to those who need to request assistance. The CoC will work with street outreach service providers and with people with lived experience of unsheltered homelessness to find accessible locations and to discuss what services are needed at these locations to make them successful. The Winston-Salem/ Forsyth County CoC understands how affordable housing and mainstream service providers are critical to the success of a 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 and providers onsite to provide services, the stronger our coordinated entry relationship will be. 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.

To educate the community, the CoC must utilize marketing strategies that include, an updated website, informational flyers, advertising, and the use of social media. The goal is to improve the knowledge of how to access homeless services and to improve the accessibility of these services to the public in a fair and equitable manner. The CoC plans to improve the education provided about services and how to access them.

### Strategy #3: Leveraging Housing Resources

To address the needs of housing, the Winston-Salem/ Forsyth County CoC will utilize alternative housing models to increase the accessibility of local housing options. The City of Winston-Salem will work closely with the local Housing Authority of Winston-Salem, 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 holding fees, double deposits, and repairs for units prioritized to those experiencing homelessness. The Winston-Salem/Forsyth County CoC will also 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 continue to 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 has acknowledged the need of providing staff to focus on landlord engagement and retention. By providing staff to collaborate directly with landlords and property owners we are expecting this would increase landlord buy in to our rental assistance programs through the CoC. This strategy the CoC utilizes case managers who will primarily be responsible for 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 such as connections to local resources for mainstream benefits, budgeting, or life skills to clients who have been housed through our various CoC programs.

#### Strategy #4: Creation of Local Healthcare Housing Resources

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 will be 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 experiences 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. Program participants will be supported by a Permanent Supportive Housing 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.

Another program, Healthcare to Housing, will be managed by another agency, Positive Wellness Alliance. This program will offer case management, provide coordination of medical, housing, dental, legal, mental health, spiritual, social, financial, and home health care services with a focus on those who are diagnosed with HIV/AIDS. This will include HIV case management along with advocacy, referral, crisis intervention, networking, and assistance with the coordination of services through government programs. Care plans will be created with clients and be reviewed every six months and updated as needed. These care plans will help identify financial and social needs, allowing the case manager to closely monitor each individual. As an extension of the program, the agency desires to start a stipend-based peer intervention model. The model seeks to stipend and train persons with lived experience to become peer intervention specialists. Research has shown that peer intervention specialists are vital to recovery retention and assisting persons with maintaining housing as well as connecting to appropriate service agencies. The peer intervention model allows persons with lived experience to engage in leadership roles alongside persons in the service community. The peer approach is an enhanced version of case management, utilizing the core activities of outreach, assessment, planning, linking, monitoring, and advocacy, but adding peer-led, skill-based training activities, coupled with a system of positive incentives designed to encourage a more healthful lifestyle.

The 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.

### **Using Data to Improve the System**

In the past, the unsheltered population was unrepresented in the homelessness data that was available to the CoC. HMIS data only represents the people who are being served in local homelessness programs, and since many of the unsheltered people in our community do not have steady connections with many of these programs, they were largely unrepresented. Street outreach staff brainstormed ideas to attempt to bridge the data gap that was affecting the unsheltered population and created an Actively Unsheltered List. This list houses the location and information of any unsheltered individual that they come into contact with during the time they are performing engagement services. This list is updated on a daily basis to keep track of our unsheltered neighbors. The creation and maintenance of the Actively Unsheltered list gave CoC members had newfound confidence that a majority of the unsheltered people were being counted every month. Despite this advancement, there are still improvements needed. The number of street outreach professionals in the CoC system is low and has recently gotten even

smaller. The team also lacks key data skillsets needed to collect and maintain robust data for the population.

To serve the population effectively within the CoC system, there needs to be adequate data usage and HMIS capacity. Street outreach efforts would need to be strengthened significantly, both in the number of staff and in the ability to collect and record data affectively. A more detailed and robust data collection and data entry process must be developed for the street outreach team since they, unlike other CoC staff, are highly mobile and do not do the bulk of their work in an office setting. This new data process includes a part-time data coordination staff person who will focus on maintaining a high-quality Actively Unsheltered List and effectively training street outreach staff. Street outreach staff will also need to utilize technology tools such as **tablets**, that allow them to access the HMIS system while they are in the field. These improvements are expected to result in a more comprehensive understanding of who is unsheltered in our community, why they are unsheltered, and how the CoC can improve services provided. Having information about the unsheltered population such as disabilities and income could propel the CoCs ability to engage with healthcare providers in filling the gap for this highly vulnerable population.

### **Addressing Local Racial Disparities**

Ensuring the 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, we are committed to a system-wide process of evaluating racial disparities in access to services and outcomes. In Winston-Salem/Forsyth County, 70% of the population is white and 30% African American. Of people who experience homelessness, the ratio 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 in and discriminated against African Americans. To help our community understand who we are serving and who is accessing our system and the outcomes they are having we must use our data to understand and address the overrepresentation of people of color and the under representation of the Hispanic population. We will utilize GIS mapping to help address these disparities in homeless assistance by analyzing local demographic patterns and system performance trends.

### **Using Best Practices**

Recognizing the profound impact that trauma has on our community and 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. Our local CoC also requires each agency to practice a low barrier approach and to utilize a Housing First approach when providing services.

## **Our Targets**

By 2026, we will:

- Decrease the unsheltered population by 60%.
- Increase the number of stakeholders involved in providing services to the unsheltered.
- Expand the Coordinated Intake Center and the CoC to offer early interventions to supportive services
- Increase housing placements for the people sleeping unsheltered.
- Address the racial inequities present among unhoused people and families and track progress toward reducing disparities.
- Expand and diversify housing programs.

## **Conclusion**

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 will 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 are 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 possible and do not experience further housing crises.

After an intensive planning process, the CoC's plan for improving services to our growing unsheltered population is housing focused, human centered, and uses our performance and available data to recognize gaps. Strategies include:

- 1) Increased capacity for street-based services, including the addition of a multi-disciplinary team who can serve a population with significant co- and tri-morbidities.
- 2) 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 including expanded capacity for assessment and coordination.
- 3) Expansion of project based permanent supportive housing options.
- 4) Creation of local Healthcare Housing options.