

NC-500: Plan for Serving Individuals & Families Experiencing Homelessness with Severe Services Needs

P-1: Leveraging Housing Resources.

P-1a. Development of New Units and Creation of Housing Opportunities- Attachment.

P-1b. Development of New Units and Creation of Housing Opportunities- PHA Commitment- Attachment.

P-1c. Landlord Recruitment

Despite Winston-Salem/Forsyth County Continuum of Care's progress to create a housing system that rapidly houses individuals the homelessness crisis continues to grow. The systemic factors driving homelessness in our community is the 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.

Currently the Winston-Salem/Forsyth County CoC utilizes landlord incentives to engage landlords to participate in the housing of individuals experiencing homelessness with rapid rehousing services and to assist with utilization of Housing Choice Vouchers. 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. Landlords also work closely with the landlord engagement specialist for support in tenant issues and concerns.

The Winston-Salem/ Forsyth County CoC understands the importance of landlord engagement. Our CoC was selected by the National League of Cities to participate in a 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. With the tools and approaches honed through this program, our CoC will be better equipped to foster housing stability for residents while meeting the needs of our small landlord community

The CoC also collaborates with the City's Human Relations Department on an Eviction Diversion group that is comprised of landlords and human services agencies. 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. By participating in the local Eviction Diversion group and providing landlord incentives, many landlords are less reluctant to work with the CoC's rental assistance programs. By creating and participating in the

Eviction Diversion program, the CoC has been able to work with multiple landlords to provide connections to resources and programs such as Emergency Rental Assistance Program (ERAP) and the Diversion and Prevention program, to assist households who are imminently at risk of homelessness. This collaboration has also helped increase the number of landlords willing to work with our CoC program for rapid rehousing services.

Even with landlord incentives, our local CoC still has trouble locating housing and landlords willing to work with our programs. A major barrier in locating housing is the ability to locate units across our entire geographic area. Currently the units that the CoC are able to identify and work with are all located in one central area. Currently our CoC houses individuals mainly within our East and Northeast ward. With more engagement our CoC believes we will be able to increase the number of property owners and diverse the areas and landlords that are willing to work with our CoC. The CoC continues to work strategically with support from the National League of Cities to improve our landlord recruitment strategies.

The CoC will utilize project move in dates compared to track exits and compare them to the enrollment dates to see how long individuals who are utilizing landlord incentives takes to be housed versus those who are not. The CoC will also look at the location of units where we are providing landlord incentives to ensure that we are reaching landlords in various parts of the Cit and lastly the CoC will track the increase in the number of landlords since the start of incentives. Through the use of data, we will be able to determine if our landlord strategy is working or if we need to update and revise the way we interact and provide incentives to our landlords.

The key lessons learned from these practices are that the CoC needs to collaborate more with landlords. Many landlords voiced how they become frustrated with understanding the requirements and paperwork and the reluctance to take tenants who may destroy their properties. By having staff who can actively engage landlords for long periods of time and having landlord incentives, we can improve the engagement and success of retaining landlords.

P-2. Leveraging Healthcare Resources- Attachment

The Winston-Salem/Forsyth County CoC will 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 emergency shelter and a one stop center, and available to provide preventative care services to those who are experiencing homelessness.

P-3. Current Strategies to Identify, Shelter, and House Individuals and Families Experiencing Unsheltered Homelessness

P3a. Current Street Outreach Strategy

The Winston-Salem/Forsyth County CoC, just like other CoC's has had difficulty maintaining staff during COVID-19. Until August of 2022, the Winston-Salem/Forsyth County CoC partnered with a local health provider to provide street outreach services. This street outreach team had a focus on serving people with severe and persistent disabilities and the chronically homeless population. This team however could no longer be managed under the existing health provider and is 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 street outreach and 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. 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.

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. 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 and bus station. 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 a part 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 with CIC 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 CoC's multi-agency outreach team meets every other week to review the status of referrals and to update one another about the current statuses of individuals living unsheltered. The CoC

works to ensure street outreach teams are coordinated with one another which requires ongoing collaboration with multiple partners including nonprofits, local government, and agencies that receive a wide range of funding sources including law enforcement, first responders, and local behavioral healthcare clinics. 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 multi-disciplinary team is 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 current street outreach strategy uses a trauma informed engagement approach to deliver services to those experiencing homelessness. Outreach teams coordinate to meet at local shelters to conduct street outreach as a team in order to be able to provide an array of services to individuals at one time. Our street outreach team is also coordinated with our coordinated entry process and have staff who conduct street outreach and complete assessments. People sleeping in unsheltered locations are assessed and prioritized for assistance in the same manner as any other person assessed through the coordinated entry process. Our street outreach providers and coordinated entry lead have data sharing agreements and protocols to allow accessibility to data. Our CoC plans to add additional support by partnering with additional behavioral health providers and local businesses owners by creating community outreach days and a one stop center.

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 staff to provide services and referrals to assist individuals with obtaining safe alternatives to sleeping outside and to refer to available 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 as needed. 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. The goal of street outreach is to ensure that individuals basic needs are

met while they are searching for housing. With increased hours and staffing, street outreach teams can better meet the needs of those that we serve.

To help people exit unsheltered and sheltered homelessness the CoC has worked collaboratively to make connections to stable housing as soon as possible while also providing additional supportive services and basic need services that meet people where they are. For instance, having mental health staff onsite at emergency shelters to provide services. The CoC for a short period of time with local funds provided mental health services to individuals residing in encampments. The CoC also works to ensure that shelters are following a low barrier approach for entry. Although street outreach does not require individuals to enter emergency shelter as a prerequisite to housing or services, having connections to emergency shelter provides a safe housing option for individuals who do choose to seek emergency housing until permanent housing is secured.

Our CoC recognizes certain groups locally, particularly African Americans and Hispanics are disproportionately represented among people experiencing homelessness. To ensure housing resources and services are being offered through a racial equity lens our CoC plans to track and analyze data on outreach engagements to ensure housing opportunities are equitably reaching people of color. The CoC will work to diversify staff in case management, street outreach, and higher management.

Our street outreach teams goals is to rapidly connect households to housing as soon as possible. The street outreach team follows a Housing First approach, meaning anyone is ready for housing. There are no preconditions that need to be met to make referrals or to advocate for housing placement. The goal is to provide housing and supportive services that can rapidly rehouse a household making homeless rare, brief, and non-recurring. The CoC provides wrap around supportive services and community resources to keep individuals in housing and make connections to community supports such as behavioral health, employment, transportation, and other local mainstream benefits.

It is very important and necessary for the CoC to form partnerships with those with lived experience. The idea of hiring and implementing individuals with lived experience in every area of the CoC presents new possibilities of implementing equitable change. When hiring individuals with lived experience at any level in an organization, especially street outreach, the CoC is able to receive knowledge and wisdom about system practices that does and does not work. Currently our CoC will be working to hire those with lived experience in street outreach and peer support case management roles. Our CoC continues to strengthen opportunities that engage people with lived experience and work to make welcoming work environments for those who are hired. Locally we value the expertise and value those with lived experience bring to help others understand and navigate services and the homeless system.

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

There are currently five emergency shelter providers within the Winston-Salem/Forsyth County CoC. The CoC requires participating shelters to follow a low barrier and housing first approach. By requiring emergency shelter providers to follow a low barrier approach, it ensures individuals are not screened out of receiving services. An effective response system ensures people in a housing crisis have access to immediately help including a safe place to go without preconditions in place that make it hard for entry. Emergency shelters are required to utilize a Housing First approach, provide safe and appropriate diversion options when possible, and have housing focused and rapid exit services. Shelters should also utilize data to measure performance and gauge changes that need to be done to ensure their shelter is meeting low barrier standards. To access emergency shelter individuals experiencing homelessness are able to go directly to shelter locations for assistance or call the Community Intake Center for information around bed availability. Currently our system does not have enough access to shelter for families with children. To increase availability of beds, motel vouchers are currently used to place overflow families in motels until bed become available in shelter.

One common theme across stakeholders is the consistent difficulty people who are experiencing homelessness have accessing a diverse set of mainstream services including emergency shelter. Many of these services are scattered throughout the City and the County causing barriers for accessibility. 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. 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, there is not one central location to receive information about homeless services or emergency shelter.

The CoC's new strategy allows individuals to access emergency shelter and homeless services from one central location. To ensure our CIC promotes fair and equal access, the Winston-Salem/ Forsyth County CoC developed a strategy to open a multi-service center one stop location which will house our Community Intake Center staff and create a viable access point for homeless assistance across the city. This center co locates emergency shelter intake staff, case management staff, intake and assessment staff, and diversion staff to assist households who seek homeless assistance. On site CIC staff provide in person triage, assessments, and referrals and resources for emergency housing, permanent 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 partial weekend hours. Individuals with lived experience will also be hired to provide support to the CIC Team. The CoC's current strategy will work with staff from street outreach programs, emergency shelters, coordinated entry, and other homeless services providers to ensure that individuals who are experiencing homelessness have access to services.

The CoC's current strategy requires each shelter to practice a low barrier approach. Our CoC received extensive two month training from the National Alliance to End Homelessness on effective emergency shelter, low barrier approaches and housing first initiatives. At this time our system only offers limited non-congregate shelter option, and that option is for families.

Throughout COVID19 our CoC utilized motel vouchers to house those who were chronically homeless, with severe disabilities and families. Through the use of motel vouchers to create a non-congregate setting, our CoC recognized the need of non-congregate shelter for those who suffer from severe mental health, physical health, and other disabilities. The CoC continues to look for additional ways to develop year round non congregate shelters for various sub populations. Currently our CoC is still utilizing the motel voucher approach to provide non congregate shelter when needed.

As a new practice during COVID-19 the CoC started utilizing motel vouchers to meet the needs of high barrier clients who were seeking emergency shelter. Motel vouchers were introduced as a way to provide non congregate shelter options for clients with high needs as well as a way to temporarily house families. From implementing these practices, we have learned our local CoC has a vast need for non-congregate shelter. When looking at data about 55 percent of the individuals with high acuity scores who resided in non-congregate shelter successfully located housing, moving from emergency shelter to permanent housing which is an increase compared to those who live in congregate settings. This helped our CoC see the need to develop this type of shelter to better meet the needs of those we serve. 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 two 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.

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

The CoC requires all organizations involved within the Winston-Salem/Forsyth County CoC to utilize a Housing First Approach to provide immediate access to low barrier permanent housing for individuals and families experiencing unsheltered homelessness. The current system prioritizes placement in permanent housing without any preconditions or requirements. The Winston-Salem/Forsyth County CoC believes anyone is ready for housing and believes housing is a basic need. The current strategy does not mandate participation in services before obtaining housing or in order to obtain housing and the CoC embraces client choice. The Collaborative applicant monitors all HUD funded programs and performs an assessment to measure a projects

performance in aligning with the Housing First model. The CoC provides monthly Housing First training sessions and has had the National Alliance to End Homelessness to provide interactive trainings around trauma informed care and Housing First.

The current strategy requires all individuals that are housed through Rapid Rehousing or the Permanent Supportive Housing program to come from the CoC's By Name List. Currently the Community Intake Center led by the United Way of Forsyth County serves as the coordinated entry process for the CoC and works with local homeless shelters, street outreach programs, and other providers to identify people with high acuity. The CIC maintains a comprehensive By Name List of individuals in need of supportive services and housing match is managed by the Director of Community Intake. This list is ordered by the clients score on the VI-SPDAT and length of time homeless. Cases are then referred to available resources and other services which will assist the household in achieving their housing stability goals. The CoC collaborates and advocates with housing providers and developers to leverage housing resources. The CoC's collaborative applicant collaborates with the CoC to utilize HOPWA, HOME-ARP, and CDBG funds to develop additional affordable housing options for those experiencing homelessness. Many of these units receive referrals directly from the CoC. The most vulnerable households are prioritized for placement and are provided with wrap around services to assist with sustaining housing. Case conferencing is done to match clients to units every other Monday at 9:00am. Once matched to a housing program, the assigned case worker works to assist the client in obtaining all needed documentation for housing and connecting them to any supportive services that are needed.

The CoC works closely with other housing resources such as HOPWA. A CoC partner, Positive Wellness alliance, provides HOPWA vouchers to eligible households that allows for permanent supportive housing placements, supportive services connection, and other additional resources. The CoC also works closely with the Veteran Affairs. Veterans are all referred to the Veteran Affairs coordinator to receive assistance with eligibility of VASH and other housing supports available within the Veteran Affairs system.

Currently when reviewing our system, we saw the need to make changes to improve the support and services provided to households who are experiencing unsheltered homelessness. To improve the services, the CoC worked to create strategies that makes services more accessible. By making services more accessible and providing more staff for engagement the CoC can improve services provided to the unsheltered population. Currently majority of resources for rapid rehousing and other housing services are being utilized by those who are sheltered. Individuals who are unsheltered need additional support in gathering documents and locating housing resources and community supports. To improve the pathways to services staff will advocate and improve engagement with those who are unsheltered by increasing the number of staff available for street outreach and ensure services are being provided through a racial equity lens. Currently the CoC has started to provide additional coordinated intake staff to provide assistance to households who are waiting to be assigned a housing case manager. This is helpful for individuals who need assistance with obtaining documents, completing mainstream benefits

forms, and connecting to any other community resources. By making additional coordinated intake staff available to meet these needs, individuals are able to rapidly locate and move into housing.

Over the past three years our CoC has worked collaboratively with the City of Winston-Salem to support and provide additional permanent supportive housing opportunities. Housing amounts locally continue to rise making affordable housing scarce. The CoC works with the City of Winston-Salem and elected officials to locate ways to increase the availability of supportive housing to those who are experiencing homelessness.

Currently the following projects are in the process of being developed:

- A 100 room motel/hotel conversion for permanent supportive housing HOME-ARP
- 8-12 permanent supportive housing units with HOME-ARP funds
- 10-12 permanent supportive housing units with CDBG-CV funds
- 10-16 units of permanent supportive housing with CoC funds, HOPWA funds, CDBG funds

P-4. Updating the CoC's Strategy to Identify, Shelter, and Housing Individuals Experiencing Unsheltered Homelessness with Data and Performance

The CoC continuously reviews and updates strategies to identify, shelter, and house individuals and families experiencing unsheltered homelessness using data and best practices. In the past, the unsheltered population was unrepresented in the homelessness data that was available to the CoC. 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 street outreach staff come into contact with during the time they are performing engagement services. This list is updated on a daily to keep track of our unsheltered neighbors. The creation and maintenance of the Actively Unsheltered list gave CoC members a 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.

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.

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 will 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 on HMIS. Street outreach staff will also utilize technology tools such as tablets, that will 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.

Street outreach activities will be connected to coordinated entry and HMIS by creating coordinated entry positions that conduct coordinated entry assessments on the streets. Staff will coordinate assessments and track services and engagement activities through the HMIS system. The CoC will create different tracking mechanisms to ensure that engagement, location of individuals, and referrals are being tracked in the HMIS system and to ensure data accuracy. Quarterly data meetings will be held to ensure data quality is being maintained.

The CoC will incorporate new partners through street outreach by creating a multi-disciplinary street outreach team consisting of law enforcement, health providers, faith based community members, and local business owners to assist with providing outreach services. Local faith based community members provide basic need services such as food, clothing, and hygiene products while health care providers are able to provide connections to community resources and assessments in real time for those who may need healthcare services. Services will be delivered by multi-disciplinary teams that can provide all person's care including physical health, mental health, social care as well as help with benefits, housing, and legal advice. The creation and integration of new partners will assist with developing the critical relationships necessary for supporting individuals transition into 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. Our street outreach effort will be strengthened by leveraging and connecting with community partners to assist with obtaining identification, locating available affordable housing units, and creating easy access to supportive services.

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 did not increase beyond 50 individuals

- 68% of unsheltered individuals are men and 31% of unsheltered individuals are women.
- Over 50% of unsheltered individuals 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%) of unsheltered individuals are identified as veterans.

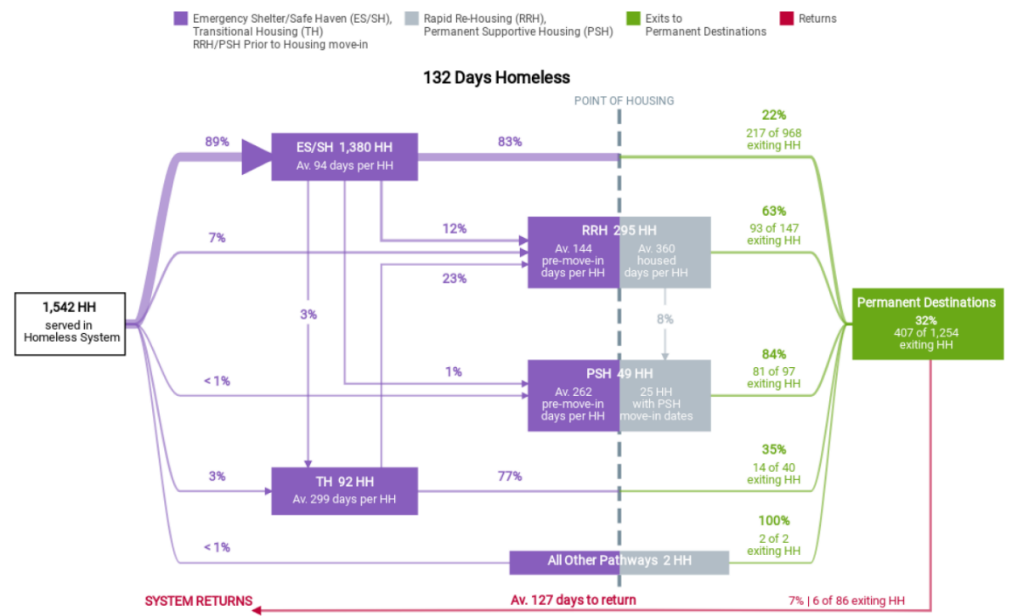
To increase the viability of shelter the CoC will provide training on effective low barrier shelters and provide trainings on how to reduce barriers to shelter entry. This training will be provided to all providers within the CoC. Emergency shelters will also be provided additional training on the Housing First Model. It is required that each agency participating in the CoC utilize this model when providing services. The CoC will also improve regional coordination and data sharing of beds by restructuring the way we utilize our HMIS system. By increasing the utilization of HMIS, the CoC will be able to track the availability of beds and better understand the utilization of our emergency shelter system.

Through coordinated entry and access to HMIS street outreach staff will be able to help connect individuals on the street to open shelter beds. The CoC will also coordinate additional strategies to address the need for non-congregate shelter. Due to the lack of availability of non-congregate shelter many individuals decide not to enter the emergency shelter system. 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. Addressing the barriers of our emergency shelter system will allow the CoC to decrease the number of individuals who are experiencing unsheltered homelessness through connection to emergency housing beds. The CoC will utilize data, performance, and best practices to expand low barrier shelter and temporary accommodation by increasing the monitoring and evaluations of emergency shelters through the use of system performance measures around bed utilization and length of stay.

New activities and practices that will be funded through an award under this competition is the creation of an additional System Administrator for the HMIS system. By creating a new role to assist with the coordination, collection, and management of data, the CoC will be able to better utilize HMIS data to understand and improve performance. One of the HUD goals of these funds is to update the CoC strategy to identify, shelter, and house individuals with data and performance. The additional HMIS system position will allow the CoC to expand capacity to work with agencies on improving data quality, data collection, and train staff on how to use data to understand and recognize gaps in the CoC system. Funds will also be utilized to provide training on best practices such as Housing First, trauma informed care, and person centered case management.

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 were residing in emergency shelter. This figure demonstrates the gap in services for those who are unsheltered who currently represent 60% of the CoC's homeless population. 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 any time. 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.

To improve data and performance, the CoC will prioritize those who are living unsheltered for permanent supportive housing and rapid rehousing services and a more robust outreach team will help to connect and engage people living unsheltered to housing services. Those interacting with the unsheltered population will utilize a Housing First approach when coordinating services. The outreach and assessment team will meet and rapidly connect individuals to housing while also assisting with completing assessment documentation and gathering needed identification documents for housing. The CIC currently 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. Through this Special NOFO, the CoC will increase the number of street outreach assessment team members to better meet the needs of the population. Data and performance metrics of the coordinated entry system as well as available housing projects performance will be analyzed on a regular basis to ensure the homeless system is effective and meeting the needs of the unsheltered population. This includes ensuring the Housing First model is being utilized and the pathways to services performance is improved to reflect individuals living unsheltered are being connected to housing services. Data from programs Annual Performance Reports and System Performance Measures can be used to improve the CoC's response to rapidly housing those who are unsheltered.

P-5. Identify and Prioritize Households Experiencing or with Histories of Unsheltered 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 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.

Our CoC's current strategy to ensure that resources provided under this Special NOFO will reduce unsheltered homelessness is to increase the accessibility of services through the coordinated entry system by creating a one stop service center, and to increase the number of street outreach staff to offer basic needs services and housing connections to those living unsheltered. With this expansion of the coordinated entry system individual's experiencing unsheltered homelessness will have increased access to supportive and housing services. Currently the Community Intake Center lead by the United Way of Forsyth County serves as the coordinated entry process for the CoC and works with local homeless shelters and street outreach program to identify people with high barriers or acuity. After meeting locally with services providers, those with lived experience, and local officials there was a major concern around accessibility and public information about homeless services.

To ensure that people who are experiencing unsheltered homelessness in our community can access services and staff, the coordinated entry process will be housed at a one stop service center. This one stop service center will include street outreach teams, supportive service providers including behavioral health, and co located intake workers from emergency shelters. This one stop service center will increase the accessibility of services for those experiencing unsheltered homelessness. The coordinated entry system will also increase street outreach assessment staff who will provide assessment and case management services on site where people are living unsheltered, this includes assisting individuals with gathering documentation that is needed for housing. By providing services to individuals where they are, this allows for people who would ordinarily not come in for services to become connected to the CoC. Outreach workers hours will be extended to allow them to engage in the field Monday-Saturday and offer extended hours throughout the week.

Currently the coordinated entry system prioritizes those living unsheltered and those with high acuity scores for housing services, however many individuals living unsheltered face barriers obtaining documentation to complete housing assessments. CoC coordinated entry and street outreach staff will reduce unsheltered homelessness by coordinated and identifying encampments and assisting with connection to supportive services including mental health and substance abuse services, connections and referrals to housing resources, and assistance with obtaining identification. The staff will also assist with connections to emergency shelter and

basic need services. Program eligibility processes that will reduce unsheltered homelessness will be the prioritization of those experiencing unsheltered homelessness. Street outreach staff working with those who are unsheltered will engage individuals with a trauma informed approach. Staff will assess basic needs and connect individuals to services for food, emergency shelter, and medical needs when necessary. The street outreach team will follow a Housing First approach, meaning that anyone is ready for housing. Staff will connect and advocate to landlords for housing opportunities that will fit the client's needs and assist clients with completing applications, gather documentation, and connecting individuals to community supports needed to sustain housing. Clients will be matched and prioritized for housing opportunities as they become available. Low barrier service delivery from the first point of engagement on the street through housing acquisition is key to helping individuals rapidly secure and maintain safe, affordable, and permanent housing.

To ensure people who are unsheltered or who have histories of unsheltered homelessness can access housing and other resources in the community the CoC has been working closely with the City of Winston-Salem to increase the availability of affordable housing units and to increase the number of permanent supportive housing units. By increase the availability of units, more individuals are able to be housed from the unsheltered population. The CoC also is working alongside the City of Winston-Salem to prioritize those experiencing unsheltered homelessness for permanent supportive housing units as they become available. Through this Special NOFO the CoC plans to increase the number of case managers to provide housing navigation services

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

The Winston-Salem/Forsyth County CoC understands the importance of involving persons with lived experience in all aspects of the Continuum of Care process. Each board within the Winston-Salem/Forsyth County Continuum of Care, (Full Council, Operating Cabinet, and the Commission on Ending Homelessness) has a seat for an individual with lived experience. The CoC also has a board titled, The Homeless Caucus that is comprised of individuals who have experienced or is currently experiencing homelessness. The Homeless Caucus meets monthly at the public library and provides input on new programs and homeless service needs daily. The CoC works to involve persons with lived experience in every aspect of the CoC process this includes having individuals serve on the Rating Panel to review and rate funding applications. During the creation of the CoC Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs CoC 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.

Currently, the CoC requires each participating agency to have one person with lived experience on their agency board. The Winston-Salem/ Forsyth County CoC continues to engage persons with lived experience and continues to explore ways to increase participation. Currently the CoC has purchased tablets with internet service to allow individuals who are serving in the Homeless Caucus and hold seats on various boards, to attend meetings virtually. The CoC has also developed a stipend policy to allow individuals with lived experience to be paid for the time they participate in various activities. The CoC continues to find additional ways to involve those with lived experience into the CoC. All HUD funded agencies are also encouraged to hire persons with lived experience to deliver services and offer peer support functions.

P-6a. Involving Individuals with Lived Experience of Homelessness in Decision Making-Meaningful Outreach- Letter of Support from Working Group Comprised of Individuals with Lived Experience of Homelessness- Attachment

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

Currently we utilize HMIS data for street outreach engagement, emergency shelter, rapid rehousing, and permanent supportive housing to determine who we are serving. This data also helps the CoC to determine the types of services that are being offered and if the correct interventions are being applied. The CoC uses this data to identify local populations that have not been served by the homeless system at the same rate they are experiencing homelessness. Ensuring the homeless service system provides the highest and best quality of services to people in our community experiencing homelessness is a critical part 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 shows a system that is overly represented by the African American population. Individuals in this population are longer term shelter stayers and make up more than half of the emergency shelter population. We must use our data to understand and address the overrepresentation of people of color and also the under representation of the Hispanic population. Currently the under representation of the Hispanic population shows that individuals in the Hispanic population are not being served.

The CoC's current strategy will be to utilize GIS mapping to help address these disparities in homeless assistance by analyzing local demographic patterns and system performance trends. Utilizing GIS mapping will allow the outreach and engagement to be coordinated in underserved populations. The CoC will also partner with local agencies such as the Hispanic League to provide collaboration with those who may need services to address the racial inequities present among unhoused people and families and track progress toward reducing disparities. The CoC's current strategy also will work to expand and diversify housing programs including ensuring shelter and housing programs are in compliance with the HUD's Equal Access Rule and the Fair Housing Act.