Assessment Report for the Continuum of Care Winston-Salem / Forsyth County

By Homebase

August 2022

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Acknowledgements

Homebase would like to thank the many people and organizations in Winston-Salem/ Forsyth County who generously shared their time and insights to help make this report possible. Special thanks to:

- Those who helped gather and decipher data from the Winston-Salem / Forsyth County Continuum of Care's Homeless Management Information System (HMIS) and other sources;
- The many people with lived experience of homelessness who provided their insights about their experiences and shared their expertise about the system;
- The organizations and their staff who hosted and/or helped facilitate small group discussions;
- The Continuum of Care who made time for us at several meetings: CoC members provided invaluable feedback about the system and the assessment; and
- Staff at the many shelters, housing providers, and supportive service providers as well as other stakeholders in the system who joined us for interviews and focus group conversations about the Continuum of Care.
- CoC staff for providing comprehensive information about the CoC, making themselves available for questions, providing support in myriad ways, and leadership throughout this process.

The feedback significantly shaped the scope and content of this report, and their contributions are appreciatively acknowledged.

WINSTON-SALEM / FORSYTH COUNTY CONTINUUM OF CARE ASSESSMENT

Introduction

The City of Winston-Salem contracted with Homebase, a national nonprofit technical assistance provider, to assess the functioning of the Winston-Salem / Forsyth County Continuum of Care ("CoC"). The CoC is a federally mandated body that is responsible for planning and coordinating services for people at risk of homelessness and those experiencing homelessness. It encompasses nearly fifty agencies, organizations, and advocates who work to prevent and end homelessness in Forsyth County. Aligning the activities of these diverse stakeholders and ensuring that available resources meet community needs is a core function of the CoC. This report assesses the CoC's strengths in carrying out its assigned functions and identifies opportunities to improve performance. A separate Action Plan identifies a set of strategies and steps the CoC might pursue to implement the recommendations in this report.

Assessment Process

Homebase's assessment of the Winston-Salem / Forsyth County Continuum of Care relied on a broad range of inputs. We reviewed existing policies and procedures, collected and analyzed system performance data, and sought input from CoC members, service providers, front-line workers, local government leaders, and people with lived experience of homelessness.

Environmental Scan

An in-depth review of existing reports and data about the Winston-Salem / Forsyth County Continuum of Care.

Two presentations to members of the Winston-Salem Continuum of Care, sharing:

- Quantitative analyses of who is experiencing homelessness, racial disparities in the homeless response system, and changes in system performance over time.
- Qualitative analyses of stakeholder feedback on CoC structure, engagement, leadership, coordinated entry, shelter and housing, data and services.

41 completed stakeholder surveys in which front-line workers, managers and leaders at local housing and service providers shared their assessment of the CoC on key components of the homeless system of care, and 21 completed community surveys in which members of the general public shared their views on what the CoC is doing well with regard to homelessness, and how it could do better.

Ten stakeholder interviews, including epresentatives from the City of Winston-Salem, community-based organizations, service providers, CoC leadership, and people with lived experience of homelessness, some of whom also participated in the focus groups and surveys.

Eight focus groups with housing providers, mainstream service providers, CoC stakeholders, local government leaders, and people with lived experience of homelessness and poverty.

Two site visits to meet service providers, people with lived experience of homelessness in Forsyth County, and local government leaders, and to host community meeting to gather public input.

Planning Meetings with City staff every two weeks.

Continuum of Care Overview

This section provides a brief overview of the Winston-Salem / Forsyth County Continuum of Care. It focuses on the purpose of the CoC, its functions and its organizational structure. It also provides a brief summary of homelessness in Forsyth County to provide context for the work of the CoC.

Purpose

The Winston-Salem / Forsyth County Continuum of Care is a regional planning and funding body intended to coordinate and support the efforts of the many people, organizations and agencies working to help people who are experiencing homelessness or at imminent risk of homelessness in Forsyth County. To that end, it brings together nonprofit homeless service providers, victim services providers, faith-based organizations, local governments, businesses, advocate groups, school systems, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, public health agencies, veteran service providers, and people with lived experience of homelessness. Through the CoC, these entities work to provide individuals and families experiencing or at risk of homelessness with housing and services appropriate to their needs.

Functions

The U.S. Department of Housing and Urban Development ("HUD") requires communities that receive funding for homeless assistance to operate a CoC. HUD identifies four parts of a continuum:

- Outreach, intake, and assessment in order to identify service and housing needs and provide a link to the appropriate level of both;
- Emergency shelter to provide an immediate and safe alternative to sleeping on the streets, especially for homeless families with children;
- Transitional housing with supportive services to allow for the development of skills that will be needed once permanently housed; and
- Permanent and permanent supportive housing to provide individuals and families with an affordable place to live with additional supportive services to help them achieve and maintain stability if needed.[1]

HUD also assigns the CoC specific tasks. These include:

[1] National Alliance to End Homelessness.

- Conducting an annual "Point-in-Time" count to document the number of people experiencing homelessness in the community at a given time.[2]
- Designating a lead entity to operate a homeless management information system ("HMIS"). An HMIS is a countywide, shared database used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at imminent risk of homelessness. Each person participates in a variety of intake and assessment surveys when they first interact with the system or are referred to a new program. These intakes and assessments provide important information about each person and household. In addition, as a person starts working with a program, information about their progress and updated assessments are stored in the HMIS as well.
- Leading planning efforts to provide housing and services to meet the needs of individuals and families experiencing or at risk of homelessness.
- Conducting an annual gaps analysis of the homeless needs and services available in Forsyth County.
- Designing and carrying out a collaborative process for development of an application to HUD for funding.
- Evaluating the outcomes of projects for which funds are awarded under the Continuum of Care program.
- Designating a "Collaborative Applicant" to serve as the lead agency of the Continuum of Care. The Collaborative Applicant is the only entity that can apply for a grant from HUD on behalf of the CoC. It does this annually based on the outcome of a CoC-led funding competition to identify programs and projects that align with HUD and CoC funding priorities. The Collaborative Applicant is also the only entity that can apply for and receive HUD funds designated to support CoC planning efforts.

Organization

A Governing Charter establishes the organizational structure of the Winston-Salem / Forsyth County Continuum of Care. It divides the CoC into four component parts:

- **The CoC "Council"** refers to the full membership of the CoC. Membership is open to "anyone interested in working on planning for homeless services and meeting the

[2] The PIT count occurs on a day in the last ten days of January. There are two types of PIT counts performed at this time: a sheltered count and an unsheltered count. The sheltered count accounts for people who are currently enrolled in temporary housing in either Emergency Shelter or Transitional Housing. The unsheltered count accounts for people who are literally homeless in other locations, such as vehicles, parks, abandoned buildings, or the streets. Under the definition of homelessness mandated by the U.S. Department of Housing and Urban Development (HUD), people who are doubled-up (more than one household in a unit meant for a single household) or couch surfing are not counted as homeless for purposes of the PIT count. The sheltered count takes place every year, but the unsheltered count is only required every two years.

mission of the CoC."[3] It includes a wide range of agencies, consumers and other stakeholders in the homeless system of care. Currently, there are about 45 members of the Council. The charter specifies that the Council must meet at least four times per year.

- **The Operating Cabinet** is a work group of the CoC Council. It consists of 20-35 Council members nominated and ratified by the CoC Council every two years. Provisions in the Governing Charter seek to ensure that Operating Cabinet membership is representative of the broad range of stakeholders in the homeless system of care. Leadership of the Operating Cabinet includes a Chairperson appointed by the Mayor of Winston-Salem, and a Vice-Chairperson, Historian-Secretary, and Financial Steward elected by the Operating Cabinet. The Operating Cabinet meets at least ten times per year. Duties of the Operating Cabinet include:
  - Consulting with recipients and subrecipients of federal funding for homeless programs to establish performance measures and targets appropriate for the population and program type.
  - Monitoring the performance of those recipients and subrecipients based on the selected performance measures and developing performance improvement plans for underperforming programs.
  - Evaluating outcomes of projects funded under the Emergency Solutions Grants program and the Continuum of Care.
  - Establishing and operating a coordinated assessment system to provide a comprehensive assessment of the needs of individuals and families for housing and services.
  - Establishing prioritization standards to determine and prioritize who will receive available housing and supportive services.
  - Establishing a written plan that coordinates the homeless system of care to meet identified community needs.
  - Reviewing grant agreement amendments before they are submitted to HUD.

The Governance Charter designates only one formal committee or work group of the Operating Cabinet: The Community Ratings Panel. The panel serves to review funding applications and make recommendations for review by the Operating Cabinet. The Operating Cabinet is authorized to appoint other committees, subcommittees, or workgroups as needed to assist the CoC in fulfilling its objectives. In the past, the Operating Cabinet has maintained several committees or work groups including:

  - Health and Mental Health

[3] Winston-Salem Forsyth County Continuum of Care website

- Homeless Caucus
- Community Intake Center
- Family, Youth and Children
- Shelter Providers
- Street Outreach Team Committee & Encampment Workgroup
- COVID-19 Coordination Daily Call

Minutes from recent meetings do not include reports from many of these committees, suggesting they may be inactive.

- **The Commission on Ending Homelessness ("COEH")** is the decision-making body of the CoC. It is charged with overseeing the implementation of the strategic initiatives and investments of the CoC. See the sidebar for details on the composition of the COEH. The Commission's specific duties include:
  - Reviewing recommendations from the Operating Cabinet on proposals to include in the CoC's application for HUD CoC and Emergency Solutions Grant funds.
  - Evaluating the performance of the homeless system of care at least once every five years and developing a plan to address any identified needs or gaps.
  - Engaging with the Operating Cabinet in the development and implementation of the CoC's written plan, which includes conducting an annual gaps analysis, and using those findings to help guide the community vision.
  - With the advice and consent of the Operating Cabinet, establishing an advocacy plan for the CoC, including the education of all stakeholders as to the issues facing people experiencing homelessness and the recommended solutions to those needs.
  - In partnership with the Collaborative Applicant, monitoring recipient and subrecipient performance using system-level and project-level measures as appropriate, evaluating outcomes, and developing performance improvement plans for those programs that are underperforming on established targets.
  - Designating an entity to serve as the "HMIS Lead" to operate the CoC's Homeless Management Information System

COEH Membership

The COEH consists of 16 voting members and 2 ex officio members, as follows:

- 5 members appointed the Winston-Salem City Council:
  - 1 with real estate background
  - 2 in business or professional practice
  - 1 with accounting background
  - 1 member at large
- 5 members appointed by the County Commission
  - 1 representative of mental health services
  - 1 representative of the Department of Social Services
  - 1 representative of law enforcement
  - 1 representative of the education system
  - 1 member at large
- 5 members nominated by the Operating Cabinet and appointed by the City
  - 1 person who is experiencing homelessness or formerly experienced homelessness
  - 2 representatives from organizations with facilities or programs on the CoC's Housing Inventory Count reports
  - The chairperson of the operating cabinet
  - 1 commissioner at large.
- 2 ex-officio members, one each appointed by the City Council and County Commission

The chairperson of the COEH is jointly appointed by the Mayor and the Chairperson of the County Commissio

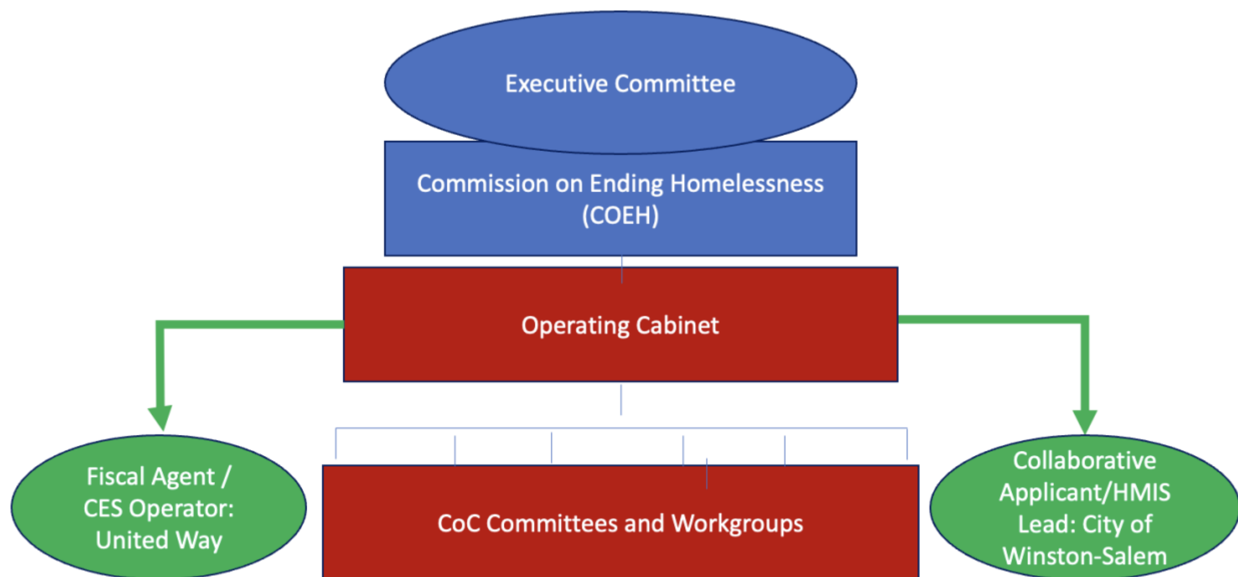
- **The Executive Committee** consists of the officers of the Operating Cabinet (Chairperson, Vice-Chairperson, Historian-Secretary and Financial Steward), and up to three members of the COEH. The Executive Committee is responsible for producing agenda items for all CoC meetings, maintaining a calendar of events for the CoC, managing the CoC's planning responsibilities, and calling special meetings of the COEH, Operating Cabinet or full membership of the CoC if necessary.

The Governance Charter also specifies certain roles that must be filled within the CoC. In all cases, either the City of Winston-Salem or the United Way of Forsyth County fills each of these specified roles:

- The "Administrator" of the CoC provides staff support to the Council, the Operating Cabinet, the COEH and the Executive Committee. The City of Winston-Salem is the designated Administrator.

- The “Fiscal Agent” administers funds on behalf of the CoC, and provides staff support to the Council, the Operating Cabinet, the COEH and the Executive Committee. The United Way of Forsyth County is the CoC’s Fiscal Agent.
- The “Collaborative Applicant” coordinates and submits consolidated applications on behalf of the CoC for HUD funding. The City of Winston-Salem is the CoC’s designated Collaborative Applicant.
- The “Director of the Coordinated Assessment System” (sometimes known as the “Management Entity”) operates a Coordinated Entry process to assess the needs of people experiencing a housing crisis and provide them with fair, equal and quick access to available and appropriate resources. The United Way of Forsyth County is the management entity that operates the “Community Intake Center” as the CoC’s designated coordinated assessment system.
- The HMIS Lead manages the CoC’s Homeless Management Information System (“HMIS”). The City of Winston-Salem is the CoC’s HMIS Lead.

Figure 1: Organizational Structure of the Winston-Salem / Forsyth County Continuum of Care



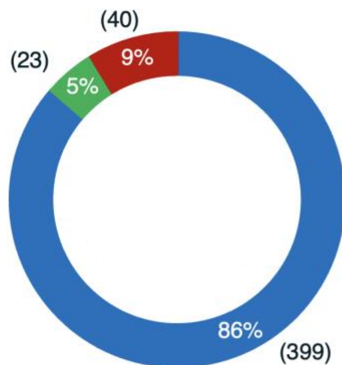
Background and Context for the Continuum of Care (CoC)

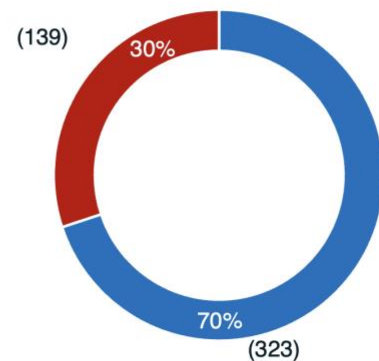
In January each year, the Winston-Salem / Forsyth County Continuum of Care conducts a count of the number of people experiencing sheltered and unsheltered homelessness in Forsyth County. It’s important to note that the number of people who experience homelessness in

Forsyth County over the course of a year is much higher than measured by the PIT count. This is because the PIT count only measures the number of people who are homeless and participate in the count on a given day. It does not account for the many people who fall in and out of homelessness during the rest of the year. The 2021 point in time (PIT) count found 462 individuals experiencing homelessness. 86% of these individuals were adults aged 24 years and older, while 9% were children under the age of 18. 30% of the individuals were living unsheltered. (Figure 2)

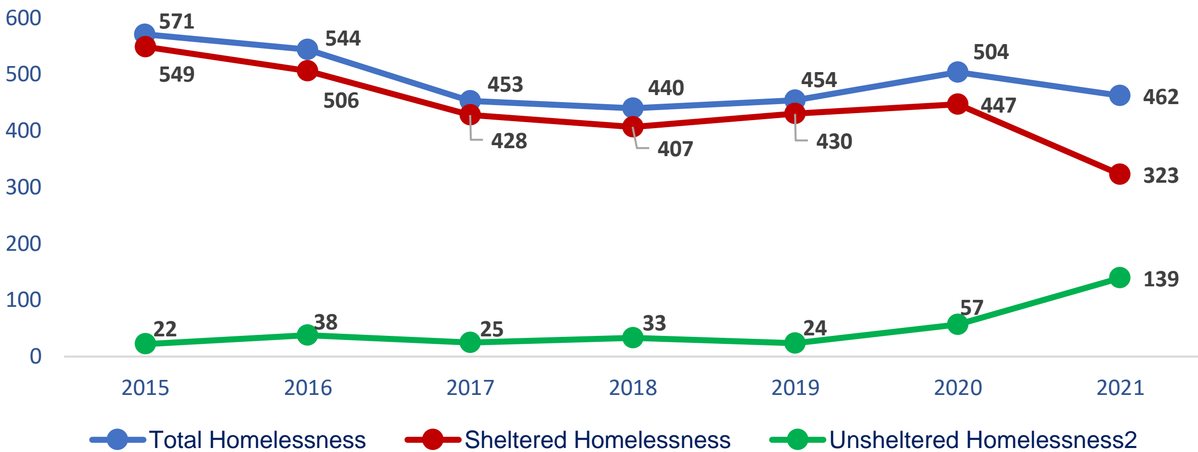
Figure 2: Individuals Experiencing Homelessness

Point-in-Time Count 2021





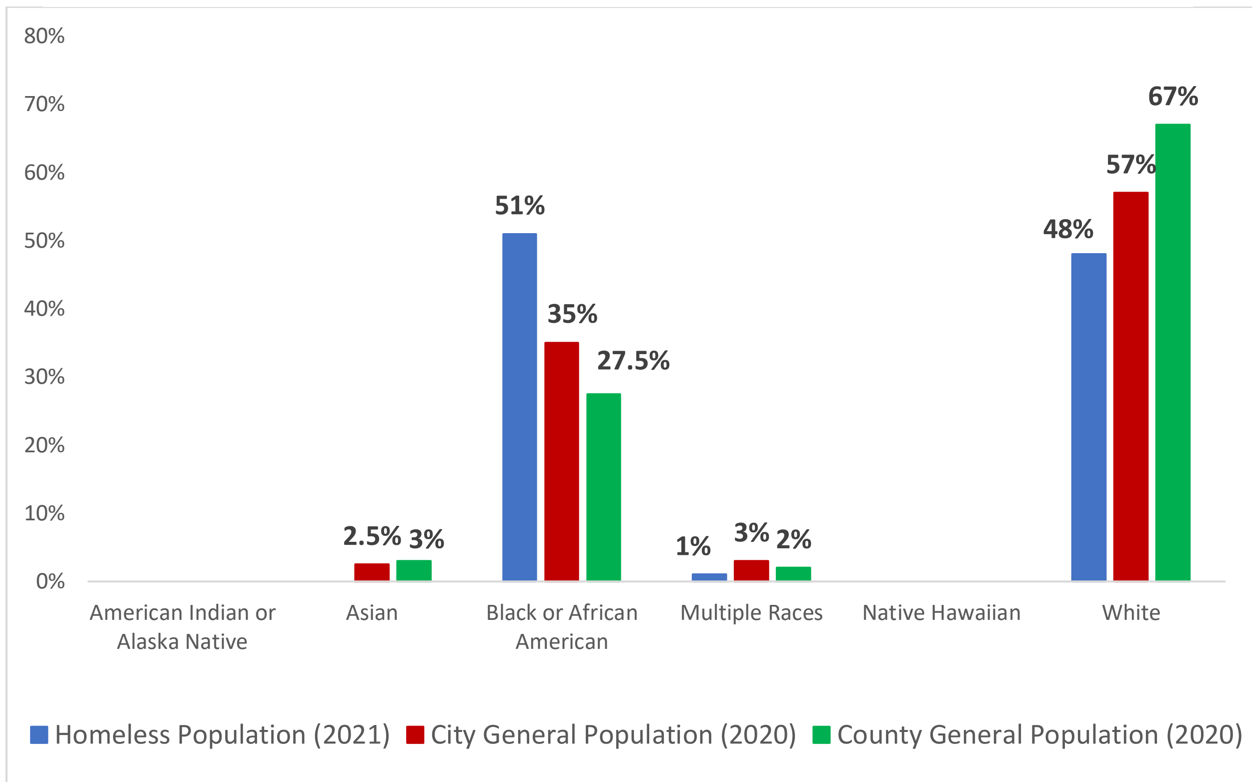
Overall, significantly fewer people were experiencing homelessness in January 2021 than in January 2015. However, data show a significant increase in the number of people living unsheltered in 2021 compared to 2015, and a corresponding decline in the number of people experiencing sheltered homelessness. It appears that this shift is due to restrictions imposed to address the COVID-19 pandemic, which limited the availability of beds, particularly in congregate settings. (Figure 3)



The data also show significant racial disparities in terms of who experiences homelessness in Winston-Salem and Forsyth County. Specifically, Black individuals are over-represented in the population experiencing homelessness, and white individuals are under-represented. The chart below shows that Black individuals make up 35% of the population of Winston-Salem and 27.5% of the population of Forsyth County. They nonetheless account for more than half of the individuals experiencing homelessness in the community. By contrast, white individuals make up 57% of the City's population, and more than 67% of the county's population, but account for just 48% of the homeless population. These disparities likely are due to the impacts of discriminatory practices and structural factors that leave a disproportionate number of Black residents under-resourced and housing-insecure.[4] (Figure 4)

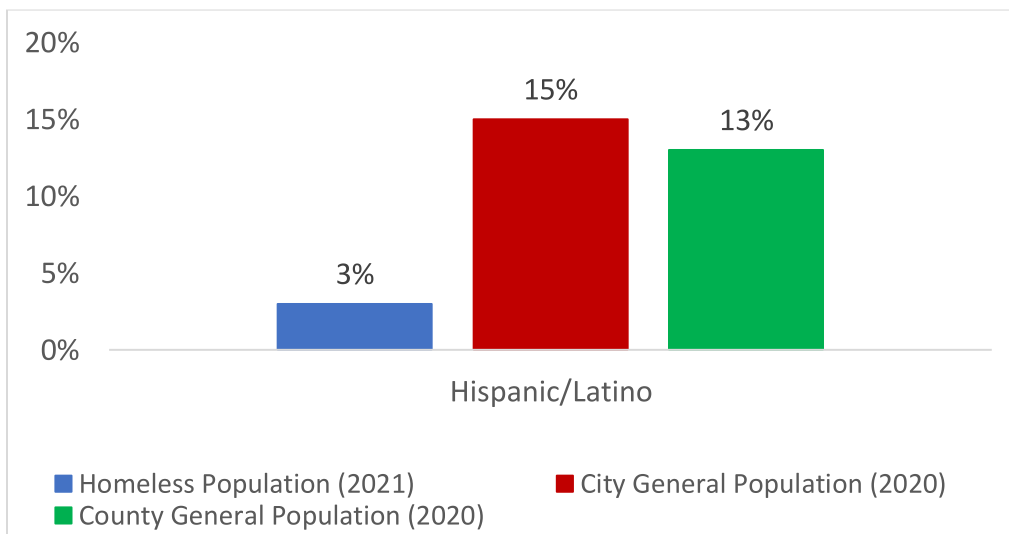
[4] For more information, please see the National Alliance to End Homelessness' discussion of "Homelessness and Racial Disparities."

Figure 4: Homeless Population by Race (PIT 2021 v. U.S. Census 2020)



Hispanic or Latino individuals are significantly underrepresented in the homeless population. Whereas 15% of the City's population is Hispanic or Latino, and 13% of the County's population is Hispanic or Latino, just 3% of the homeless population is Hispanic or Latino. (Figure 5)

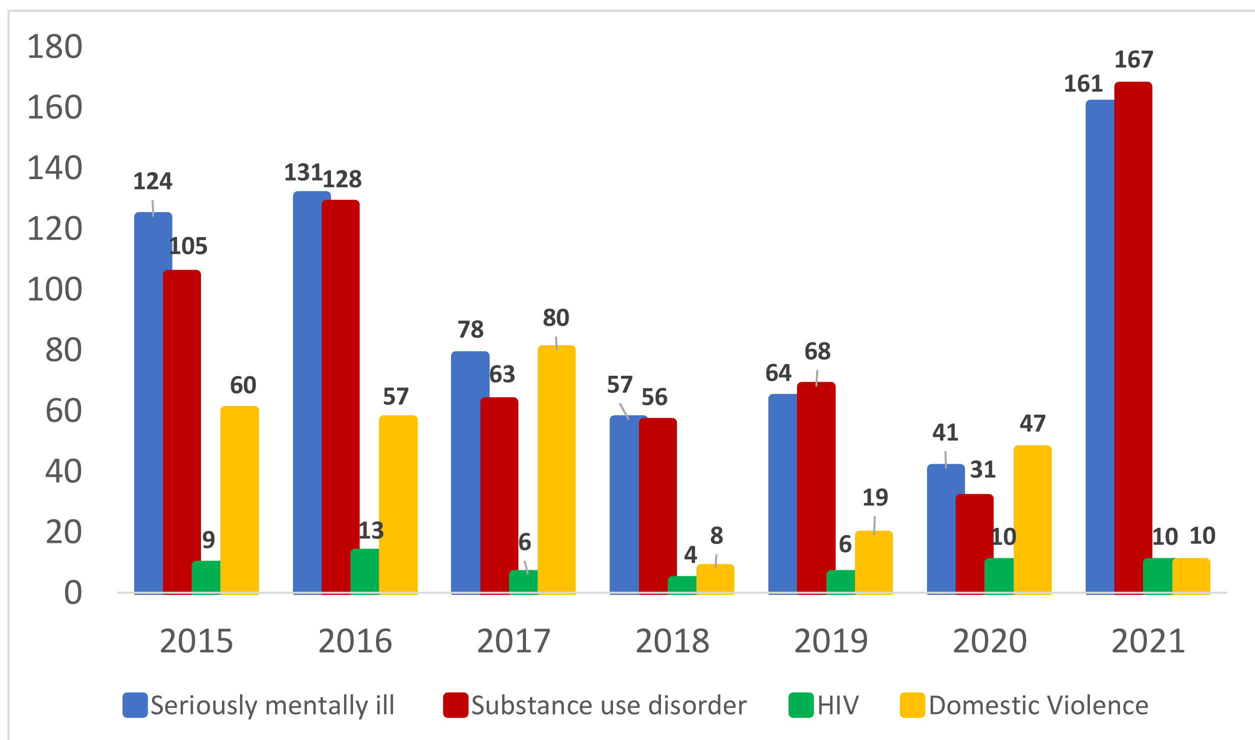
Figure 5: Homeless Population by Ethnicity (PIT 2021 v. U.S. Census 2020)



This is a surprisingly low figure. About 33% of the Hispanic or Latino population in Winston-Salem had incomes below the poverty line. (By contrast, about 19% of the total Winston-Salem population had incomes below the poverty line). This suggests a high vulnerability to economic dislocation and housing instability. That Hispanic and Latino individuals are so significantly underrepresented in the homeless population may indicate a need to strengthen outreach efforts and support culturally sensitive and specific service providers to reach the population.

The Winston-Salem / Forsyth County Continuum of Care serves a wide variety of subpopulations. There was a significant spike in 2021 in the number of clients experiencing serious mental illness or with a substance use disorder. (Figure 6) Local service providers speculate that the sharp increase is closely related to the spike in the number of people living unsheltered in 2021. Unsheltered homelessness is extremely stressful and likely exacerbated existing problems with mental health and substance use. At the same time, there was a significant decline in the number of individuals experiencing homelessness who were fleeing domestic violence, dating violence, sexual assault, and stalking (collectively represented as "Domestic Violence" on the chart). Local service providers cautioned that the number of people experiencing domestic violence who need housing may nonetheless remain high. They speculate that, due to concerns over the dangers of COVID transmission and the difficulty in securing non-congregate shelter, many people experiencing domestic violence – and especially

Figure 6: Homeless Population by Additional Populations (PIT 2015-2021)



those with children -- remained in the housing they had, despite the abuse or potential for abuse they faced there.

Assessment

The purpose of our CoC assessment was to help the Winston-Salem / Forsyth County Continuum of Care identify opportunities to improve the existing system. At the completion of the Assessment, Homebase identified seven issue areas where improvements can be made to strengthen the day-to-day and strategic approach of the CoC:

- CoC structure
- Leadership
- Engagement
- Coordinated Entry
- Shelter and Housing
- Data
- Services

In the discussion below, we highlight the concerns that stakeholders raised in each of these areas and identify steps that the CoC or others could take to strengthen the processes and protocols.

It is important to recognize that stakeholders also highlighted many strengths and accomplishments of the CoC. Perhaps most-frequently mentioned was the CoC's response to the COVID-19 pandemic. Stakeholders praised the speed with which the CoC moved to address the situation and the coordinated and effective response that it achieved. The CoC held daily calls to coordinate efforts and share learnings. Members also established plans for sheltering medically fragile individuals and for isolating individuals impacted by COVID-19.

> *"I commend them for how they were able to keep people as safe as possible. Having a medically fragile shelter and other necessary responses – it was a great response."*
>
> -Interviewee

Another strength, for some, is the support they receive through the networking that the CoC facilitates. Stakeholders appreciated the ability to reach-out to other service providers to help meet the needs of people experiencing homelessness. In our observation, however, those who saw this as a strength of the CoC tended to have a long association with the homeless system of care in Forsyth County. As discussed below, newer staff and agencies that are relatively new to the CoC tend to feel isolated from other members and uninformed as to the resources available from or services offered by other CoC members.

> *"I will say that I do like the fact that we pick up the phone and talk with each other when it comes to CIC receiving referrals."*
>
> — Interviewee

The CoC practice of holding "Action Camps" also received particularly strong praise. Action Camps were monthly meetings used to identify challenges in the system or opportunities for improvement, and work collaboratively to develop solutions. The CoC set-aside the practice of holding Action Camps amidst the challenges of responding to the COVID-19 pandemic. Many stakeholders called for the return of Action Camps to continue the work of building a stronger CoC.

Another strength of the CoC is its written policies and procedures. From its Governance Charter, to written standards for the provision of housing and services, to the Community Intake Center Policy and Procedure Manual, we found that the CoC maintained written policies and procedures that generally complied with HUD requirements and reflected well-accepted practices in the field. While we did not scrutinize every provision for legal compliance, on the whole the CoC should receive high marks for the strength of its written policies and procedures. One issue noted by some was that the practices in the CoC do not always follow the written policies and procedures or align with the goals outlined in them.

> *"The CoC does have some good points to it. One of the positive benefits of the CoC is they have a collaborative support structure among the different agencies. And they are very good at sharing financial and information resources among each other. Where someone can get help with clothing or dental care or medical care or food."*
>
> — Interviewee

Structure

As discussed in more detail above, there are four component parts of the CoC:

- The CoC Council, which consists of the full membership of the CoC, and includes a wide range of individuals and organizations, including service providers, agencies, religious organizations, advocates and people with lived experience of homelessness.

- The Operating Cabinet, which is a group of up to 35 members of the CoC, elected by a vote of the CoC Council, and selected to be representative of the many stakeholders in the CoC;
- The Commission on Ending Homelessness (COEH), which has 16 voting members, including 5 named by the Operating Cabinet, 5 named by the City of Winston-Salem, 5 named by Forsyth County and a chairperson appointed by the mayor of Winston-Salem.
- The Executive Committee, which includes the officers of the Operating Cabinet and up to three members of the COEH. The Executive Committee convenes meetings of the CoC and sets meeting agendas, among other duties.

Functionally, the Council and the Operating Cabinet and its committees and workgroups are largely advisory. The decision-making authority of the CoC is held by the COEH. In practice, the Council and the Operating Cabinet serve principally as mechanisms for information sharing. A review of the minutes of the two bodies shows that members spend much of their time receiving program updates or reports on discussions held by each body and by committees or workgroups. Occasionally the Council and the Operating Cabinet make recommendations on matters for consideration by the COEH.

A large portion of COEH meetings is also dedicated to information exchange. COEH members frequently hear reports about discussions held by the Council and/or the Operating Cabinet, and members may discuss these topics as well. The COEH also reviews and approves policies to govern CoC operations. When appropriate, it also reviews recommendations from the Community Ratings Panel on funding applications and makes its own recommendations to the Collaborative Applicant on these same applications. City Council members reported that they rarely hear from or interact with the COEH.

Staffing for the CoC, including for the activities of the Operating Cabinet and the COEH, is provided by the City of Winston-Salem in their role as the CoC Administrator and HMIS Lead and the United Way of Forsyth County as the CoC's Fiscal Agent and Coordinated Entry System Operator (Community Intake Center).

CoC stakeholders raised a number of concerns related to the complex structure of the CoC and its impact on operations and member participation.

Bureaucratic and hierarchical

To many participants, the CoC feels both bureaucratic and hierarchical. Participants complained that the CoC held many meetings and yet it often felt like little was accomplished. Similar information was presented over time and across the various CoC meetings. This led to

> *"They are good about having meetings to discuss issues, but I see little to no actual solutions being enacted."*
>
> — Stakeholder Survey Respondent

frustration and questions about the efficient and best use of resources and CoC expertise. Some participants also felt that "CoC meetings are one-way." Focus group and survey participants reported that at times the meetings involve "lots of telling people about things, but not a lot of discussion." Several participants were also concerned that decision-making power is closely held at the top of the CoC, with little opportunity for front-line staff to weigh-in or be heard. As a focus group participant commented, "Structurally, executive members [go] to the CoC – case managers only [go] for special meetings…and [are] not a regular part of the CoC."

The complex structure of the CoC also leads to a lack of clarity regarding roles and responsibilities. This can make it hard for members to exercise leadership within the CoC, or to establish and maintain systems of accountability to sustain initiatives and move them forward. New members find it difficult to understand CoC structure, operations and decision-making authority. As one survey respondent noted, "It's unclear to me how the full CoC meetings are substantively different from the Operating Cabinet. More clarity on their goals would be helpful. Perhaps a more intentional orientation as new members move onto the Operating Council or the full CoC."

Reduced/low participation

CoC members reported being discouraged by the layers of bureaucracy and lack of action within the CoC. One survey respondent noted that, "we discuss things a lot but there is little follow up or follow through." Several stakeholders observed that only a small number of CoC members actively participate in the CoC and that "it's always the same group of people." This has been taxing for those who do participate and may signal that CoC operations are not structured in a way to encourage participation. As a focus group participant observed, "There are rarely new voices or passion in meetings because there is no encouragement to participate."

> *"We rarely [hear] what is happening with [C]ommission meetings."*
>
> —Stakeholder Survey Respondent

Inefficiencies/duplicative processes

The CoC's structure leads to inefficiencies and duplicative processes. CoC members reported that different committees and work groups often take up the same topics for discussion. "There is a lot of repetition between Operating Cabinet, full Council and 2:00 calls." Moreover, by the time topics reach the COEH for decision, they have often been considered by the Operating Cabinet, referred to committee, returned to the Operating Cabinet with a recommendation, voted-on by the Operating Cabinet, and, in some cases, considered by the full CoC membership. This long chain of deliberation contributes to the feeling that little gets accomplished within the

CoC. As one survey respondent observed, "It seems that the agenda items and issues remain the same over the years. In other words, real progress is either not made or not celebrated."

Recommendations:

In view of these concerns, Homebase makes the following recommendations:

1. **Revise the current governance structure of the CoC** to create opportunities for better decision-making and greater participation from CoC members.
    a. **Recast the Commission on Ending Homelessness in an advisory role** to serve as an intermediary between the County Commission, Winston-Salem City Council, and the CoC. Leverage the diversity of experience and expertise of the various COEH members through collaboration on strategic initiatives and community planning.
    b. **Revise the role of the Operating Cabinet of the CoC** in the following ways:
        i. Empower the Operating Cabinet to be the primary decision-making body (the Board of Directors) of the CoC membership.
        ii. Create an Executive Committee specific for the Operating Cabinet with no more than eight members. Continue to have representatives of the Operating Cabinet act as liaisons to the COEH/Winston-Salem City Council and the County Commission.
        iii. Ensure diverse representation on the Operating Cabinet.
2. **Adopt a formal committee structure.**
    a. Clarify the role, function and membership of existing committees and workgroups.
    b. Determine whether new/different committee and workgroups are needed.
    c. Annually evaluate the committee structure.
    d. Ensure committees are empowered and action-oriented to be able to make decisions and act on those decisions on behalf of the CoC within the scope of their assigned roles.

Leadership

The leadership of the CoC includes several organizational bodies and staff, including the CoC Council (the full membership of the CoC), the Operating Cabinet (considered a work group of the CoC Council), the Commission on Ending Homelessness (the decision-making body of the CoC), an Executive Committee (comprised of the officers of the Operating Cabinet and up to three members of the COEH), and staffing to the CoC, which is primarily shared between two entities: the City of Winston-Salem and the United Way of Forsyth County. The City is the

administrative entity, the HMIS Lead, and the Collaborative Applicant (for purposes of HUD annual CoC Program funding) for the CoC. The United Way is the Fiscal Agent and is responsible for the Coordinated Entry System (known locally as the Community Intake Center) for the CoC. Both the City and the United Way provide staff support to the Council, the Operating Cabinet, the COEH, and the Executive Committee.

While the different entities work hard to further the goals, mission, and work of the CoC, stakeholders shared in interviews, focus groups, and on surveys three primary concerns with CoC leadership, including staff support:

- Concentrated power within the CoC rests almost exclusively with the two entities;
- There are currently inherent conflicts of interest with the structure as it exists; and
- Decision-making is not as strategic, data-informed, nor inclusive of the CoC membership as it should be.

Concentrated power

The relative roles of the Executive Committee and Officers of the Operating Cabinet, the United Way, the City of Winston-Salem, and other member organizations in the CoC are unclear to many active in the CoC. Questions stakeholders raised that demonstrate the confusion include: Who really is the CoC in Winston-Salem / Forsyth County? Who are the staff? What does it mean to be staff? What does it mean to be a lead agency? Who has the authority? Who decides and when and why can they do so?

> *"We have had the same people for a long time – and I think sometimes change is good."*
>
> — Interviewee

There is some sense shared across stakeholders that the existing leadership is not connected to the day-to-day work of the CoC. One survey respondent made a comment that contained common sentiments: "There needs to be new leadership. Or if [the] same leadership remains in place, when is [the] last time they have visited a shelter or had to go through the process? Leadership seems far removed from empathy [toward] the population."

> *"I think the most effective leadership comes from folks that have previously been boots on the ground in the field that prioritize folks experiencing homelessness and related issues over politics/political pressure. As a whole I think our system isn't good at having direct and honest conversations and holding organizations accountable & helping them to work more effectively for the folks they serve."*
>
> — Stakeholder survey respondent

During one of the focus group interviews, a discussion arose focused on how power is exercised in the CoC. Some members felt that when they offered to provide additional assistance to increase the capacity of the work overall, those who were already doing the work did not want to share and make room for new people. Others affirmed and said they felt like there were "turf" issues that made it difficult to collaborate and/or expand the work the CoC was able to accomplish.

Many stakeholders shared that they feel as if all voices are not equal in the CoC – both in being able to speak up, but also in how they are treated by CoC leadership. Stakeholders felt that only a very small group of individuals even feel comfortable speaking up in the meetings, which means those staff and organizations who do end up engaging have tremendous influence in what the CoC does.

> *"Leadership holds on to power and authority with great control to the point where my voice is tolerated but I don't feel like anything I input into the meetings truly makes any difference."*
>
> — Interviewee

Some of the most common feedback in the stakeholder engagement process was that there is concentrated power in the existing staffing provided by the United Way of Forsyth County (United Way) and leadership of the CoC. Many felt that power was concentrated and not spread sufficiently across the many organizations that participate in the CoC. Some mentioned feeling mistreated or intimidated by that staff. Others noted that when that staff had an interest or thought about a subject, that issue would often get more attention than others in the CoC.

Many stakeholders mentioned not feeling "safe" speaking up at CoC meetings. That feedback came from a variety of organizations active in the CoC, and from other stakeholders within the CoC – both people fairly active who do speak up at the meetings as well as organizations and staff on the periphery of the CoC. People shared about their first-hand experience of having input or feedback but not wanting to contradict staff from the United Way because they also provide necessary funding for their agencies or organizations. They also shared instances of watching other members speak out and be mistreated.

> *"The biggest thing is not just being at the meeting, but the engagement in the meetings. People feeling safe. When you have funders in the same meeting, you feel like you can't be open as you want to be, even if it can be effective. We are in an ever-changing society about what we can do better, sometimes those are challenging and hard conversations. Don't think some of us feel safe enough in that space."*
>
> — Focus group participant

Stakeholders' perception is that the United Way is the primary entity that communicates on behalf of the COEH and Operating Cabinet and to the general membership. Many stakeholders

raised the concern that they does not always listen to what others have to say. Further, participants shared that sometimes their staff would come to a meeting with an agenda but while presenting at the meeting, it would appear as if decisions had already been made outside of the meeting and the CoC process. Many participants mentioned coming to meetings and feeling as if decisions were not still on the table and that their staff were not open to hearing other points of view.

> *"The CoC stick[s] to a few favorite topics, and that's about it. Most of the members are isolated by a security desk, an elevator, and a sheet of glass, that they very rarely look out of."*
>
> — Stakeholder survey respondent

When stakeholders mentioned the City of Winston-Salem team, they raised concerns that it seemed that staff are not able to go out in the community. While stakeholders recognized that many new City staff came into their positions during the COVID-19 pandemic, they still felt some frustration about how staff were not connected more deeply with the workings of the CoC. There had been an expectation that the City staff would help with the problems with the structure and function of the CoC and since that had not yet happened some participants were frustrated. The two new positions in the City, however, were both temporary, funded through federal COVID-19 resources to increase housing navigation and housing placements. Some stakeholders expressed hope that through this assessment process the City could still help achieve meaningful change in the CoC.

> *"They don't have any leadership within the City. They created these positions in the hope that they would be able to go out and fix what was going on and that isn't the case. No leadership and no training. They were put there just to figure it out."*
>
> — Focus group participant

Conflict of interest

Whether there is an appearance of a conflict of interest or an actual conflict of interest, stakeholders feel like it is challenging to be active in the CoC when the United Way of Forsyth County holds a key leadership position in the CoC and also controls how resources are distributed in the larger community. The fact that the agency controls other funding in the community has resulted in a difficult power dynamic

> *"I am an observer. I learned very quickly – I thought the United Way was the CoC – every suggestion was coming from that direction. Making comments or suggestions in a meeting, nice moment of silence and then the next topic happens. I get it, people need time to process. If leads don't suggest it, it's not a good idea."*
>
> — Focus group participant

for stakeholders who are afraid to speak up or push back, fearing that their other funding might be put at risk. More than a few stakeholders mentioned that some people feel like it is hard to be safe and speak out at meetings when funders are there and if you do not say something they like, they could withdraw funding or hold it against you in the future. In addition, some questioned whether it was fair for someone in that position to receive large amounts of CoC funding and help advise decision-makers about how to evaluate programs and make allocation decisions for CoC funds.

While the CoC is comprised of many organizations, stakeholders said that the members of the key leadership team are at almost every Committee meeting too. Some stakeholders felt that this stifles energy to some degree. They would like to see the opportunity for on-the-ground staff to lead these efforts without the oversight (and express or implied consent) of the leadership team. The notion shared by many was that a single agency dominates the CoC, rather than the CoC being a collaboration of all the partners.

> *"The buy-in for new ideas, when they were presented, [is] a little biased. It depends on who was making the proposal or idea. Any time the United Way wanted to have a revision to something or alter some policies or whatever, it was [their] way or [their] way of doing was pretty acceptable. If someone opposed that, and not 100% agreeable or majority – it was a mess. The meeting just stopped right there and was rescheduled to the next meeting date and they would deal with it later. That's pretty much my experience with the CoC."*
>
> —Focus group participant

Decision-making

The concentration of power described above impacts decision-making in the CoC. The stakeholders expressed a desire for a more strategic CoC that engages more subject matter experts, a diversity of staff, and more people with lived experience.

> *"United Way is the voice of the providers, but I don't always agree with their reasoning. They don't hear us out all the time. They look at things in terms of numbers and data. If things aren't resolved, it goes however United Way wants it to go. We used to have the opportunity to address issues. But that has changed."*
>
> — Interviewee

> *"We used to have the opportunity to address issues. But that has changed. They [Staff] go by their agenda."*
>
> — Interviewee

Stakeholders seek decision-making within the CoC that is grounded in data and less subjective. They would also like to see more follow-up discussions after decisions are made with progress reports and return on investment analyses. They would like to see more time set aside for decision-making, with more input encouraged and more voices heard, and more structure to creating the meeting agendas and the decision-making processes in general.

> *"If things aren't resolved, it goes however [staff] wants it to go."*
>
> — Interviewee

> *"It's almost like other agencies don't have a voice, what others say is not pertinent enough or something. [Staff] always has the right answer and the pendulum shifts to their end, more times than not."*
>
> — Interviewee

> *"Shared housing came up but some case managers shut that down. People say we are tired of talking about it. We aren't doing anything. We have a lot of meetings. Would like some concrete actions and some solutions. Keep talking about the same things through Committees, Workgroups, and meetings. Bring it all together and do something."*
>
> —Focus group participant

Recommendations:

1. **Empower the newly configured Executive Committee to create agendas for and facilitate meetings of the Operating Cabinet**
    a. Use Executive Committee meetings to generate agendas for upcoming Operating Cabinet meetings.
    b. Ensure that all CoC members know they can propose agenda items for Operating Cabinet meetings in advance, through any of the Executive Committee members or through a clear submission process.
2. **Clearly delineate roles and responsibilities of staff and organizations supporting the CoC,** to ensure the CoC's priorities are moving forward, and members are actively participating
    a. Develop clear roles and responsibilities of staff and/or organizations supporting the Operating Cabinet, the Executive Committee, the Community Intake Center (CIC), and the Commission on Ending Homelessness.
    b. Communicate to the CoC membership the identified roles and responsibilities of each staff person and organization.

c. Provide reference materials for members to refer to on an ongoing basis about the roles and responsibilities of staff and lead organizations.
d. Establish regular meetings among Executive Committee members and staff from supporting organizations to enhance coordination.

3. **Create new processes for Operating Cabinet meetings**
   a. **Determine regular facilitation of Operating Cabinet meetings**.
      i. Consider rotating facilitation shared by each of the Executive Committee members.
      ii. Ensure the notes are shared CoC-wide within one week of Operating Cabinet meetings.
   b. Ensure **Executive Committee is regularly soliciting agenda items** from the CoC membership.
   c. **Structure Operating Cabinet meetings to follow a framework** that focuses on key issues, analyzes existing data and needs, reviews evidence-based practices and research, and is solution-focused.
4. Conduct introductory trainings for everyone in the CoC**, including the new Executive Committee all Operating Cabinet members, and all Commission members.**
   a. Trainings for all participants should include, at a minimum, basic information about the new governance structure, the roles of each of the different bodies (COEH, Operating Cabinet, Community Intake Center, etc.), and a CoC 101 training.
   b. Conduct ongoing member orientation to new CoC member organizations and individuals, which should include all of the above topics, plus other strategic topics that reflect current activities of the CoC.
   c. Consider creating a buddy system for new CoC members or individuals to be matched with already active CoC members who can provide context, history, and any other additional information that would help integrate new members into becoming active participants in the CoC.
5. **Address members' concerns regarding perceived/real conflicts of interest** and potential for retaliation.
   a. Adopt and implement a Conflict-of-Interest Policy to ensure decisions of the CoC and of CoC/ESG-funded entities are free from bias or conflict or the appearance of conflict and have all Board members, funded agencies and staff sign a conflict of interest form each year[5]. (Example provided in appendices).
   b. Require that any organization that serves as staff to the CoC maintain policies and procedures to guard against real or perceived conflicts of interest and

[5] 24 CFR § 578.95 Continuum of Care Program Interim Rule Subpart F - Program Requirements Section **578.95** - Conflicts of Interest.

potential for retaliation, particularly in the distribution of non-CoC funds it otherwise controls.

c. Provide confidential mechanisms through which CoC members can raise concerns about potential conflicts of interest or retaliation and have them investigated.
d. Regularly survey CoC members on any concerns regarding potential conflicts of interest and retaliation.

Engagement

Even those who are participating in the CoC identified the need for greater engagement, especially as a group. Stakeholders identified that there really is no formal training or orientation for new members. During a focus group, participants shared that their orientation was informal and that they were asked, "what do you want to know," rather than being provided background and context on the CoC or an overview training. For some people joining from organizations that were not familiar with the CoC, this made it difficult to engage.

> *"When they started, there were no orientation trainings for new people, so they had to train themselves."*
>
> — Focus group participant

Stakeholders also shared that it is difficult to keep people at the table, engaged, appreciated, and valued. They seek ongoing opportunities to train and learn more about how the system is supposed to work. People expressed confusion about the training requirements and policies of the CoC. Some recognized that the CoC offers trainings but questioned whether the trainings were open to everyone who needs to participate. In one meeting, a participant indicated that they were told that only the Executive Director and one other person could attend. Others shared that there is often short notice provided for the trainings, which limits who may be available to attend. Further, the timing of the trainings can prevent front-line workers from being able to attend even though the subject matter is most applicable to them.

> *"Try to have representation across all different types of organizations, but it doesn't stay that way. Have a hard time to keep people engaged or people seeing their worth on the board. When that happens, we really need everyone all the time."*
>
> — Focus group participant

There was also confusion amongst stakeholders about when various meetings occur and who can attend them. In one focus group, attendees shared that there was a bi-weekly rapid rehousing (RRH) meeting and a separate bi-weekly assessment team meeting on the off weeks. Only some of the people in the focus group who should have been in those meetings were even aware that they occurred. Another issue that was raised by stakeholders was that not everyone is clear of the value of a meeting and therefore do not always participate.

> *"Biggest thing –how do you keep key players at the table and how can we show them their worth."*
>
> — Interviewee

> *"I feel disconnected from the work of committees. Not sure if that's because I arrived during COVID, or because I am an outsider."*
>
> — Stakeholder survey respondent

It does not appear that the CoC policies themselves are confusing, but that in practice the organizational approach or culture has left the impression that there are rigid standards and/or that people are not always welcome.

> *"You come on and are thrown into the fire. That shouldn't have happened. Leadership could do a better job at ensuring the understanding of new people coming into programs."*
>
> — Focus group participant

Collaboration and Coordination

While individual participation and engagement was raised as a concern, another opportunity for improvement was around coordination and collaboration across members and organizations. Stakeholders identified that programs need to work better together, to collaborate and work in tandem. There was some sense that the work is somewhat siloed, so that, for example, shelter and rapid rehousing providers were not working together as much as they could.

People also felt that they are often left to take care of themselves; that there is little effort to get help from one another in the CoC. For those who can collaborate and support one another, it is often informally,

> *"Navigating the resources is challenging at best – there is a lack of streamlined approach or coordinating approach – here's one place we need to go. Some of the work is duplicative. If we only had relationships that were better established. There might be a [client] who all of our teams are working with and we don't know that…. We often send families in different directions. We are working in two competing directions and that's not good for anyone either."*
>
> — Interviewee

not through the structures of the CoC. Some people said they felt like they just have to take care of themselves.

Feedback we received was that the community would benefit from getting to know one another better. Clearly that has been impacted by COVID-19, with less in-person opportunities to build community. Our sense from the stakeholder engagement and surveys is that a focus on building a stronger sense of community would be highly beneficial.

> *"I came to my position during COVID so have not met many of the Operating Cabinet members in person. In my opinion, the group needs to spend more time getting to know each other, which is hard to do online and with everyone's limited time. I'd like to figure out a way to get at root causes, to get more in depth on many topics, and to explore ways to get more engagement going in these meetings."*
>
> — Survey respondent

Communication

An additional challenge that exists is communication. While organizational representatives attend meetings, it is not clear if they are fully communicating to the people that they work with or to other parts of the CoC. For example, we heard that CoC members rarely hear back about what happens at COEH meetings, as if it is a one-directional relationship. We also heard that people who attend meetings don't always share the information back to their own teams.

> *"When someone new comes in, if they aren't sure of their role or what their role could be or they don't feel welcome… We need a welcoming committee or something worth that to make people feel welcome and like their work is appreciated and we need many hands. We have always historically good collaborative partnerships."*
>
> — Stakeholder survey respondent

> *"Most of the front-line staff are overnight, etc. There is no attempt to schedule around needs of front-line staff and no input collected. [We] need more notice that [a training] is coming and is once a week for four weeks. It limits who can come and then end up with the manager and Executive Director."*
>
> — Focus group participant

Communication was also identified as an issue regarding opportunities to attend trainings. Stakeholders shared that for front-line staff, it would be helpful to have a training schedule far in advance, so that they could ensure their ability to attend. In practice, we heard that notice about trainings happens at most two to three weeks in advance, which is difficult for front-line staff to

schedule around. Stakeholders across many different roles in their organizations seek opportunities to attend trainings and would like to see those opportunities with more advance notice so that front-line staff are able to plan and take time away from their day-to-day work in order to attend without straining other staff or the system.

Involvement of People with Lived Experience of Homelessness

Persons with lived experience felt that their opinions and input are not always valued by members of the CoC because they may not have the same credentials or experience. They point out that they do have first-hand knowledge about homelessness and how the system operates and think that expertise should be valued. While a Homeless Caucus formally exists, its role, responsibilities and composition are not identified in the CoC's governance charter. Typically, a Homeless Caucus is comprised of people with lived experience of homelessness, representing a wide range of backgrounds and experiences. However, the Homeless Caucus has had a difficult time sustaining membership. Restrictions on meeting in person during the COVID-19 pandemic exacerbated these challenges. With the easing of those restrictions, leaders have attempted to reinvigorate the Homeless Caucus in recent months. There is one designated seat for someone with lived experience on the COEH, and the Operating Cabinet also has one seat for people with lived experience. The Governance Charter does not specify that these seats are to be filled or even nominated by members of the Homeless Caucus.

> *"There is a need to uplift voices of those with lived experience and provide them with a platform to make change."*
>
> — Stakeholder survey respondent

Lacking an active Homeless Caucus, the CoC has repeatedly relied on a single individual with lived experience of homelessness to serve as the voice and representative of all people with lived experience of homelessness in the community. To the extent that others are engaged with the Homeless Caucus, there is no mechanism to integrate their voices into the discussions and operations of the CoC.

> *"I know there are persons who have experience of homelessness, but I wish there were more people who have recent experience of homelessness. If there is a revolving seat, maybe a seat on the board that a person holds for a year, and it is very specific who sits in that seat – someone who has been displaced or unhoused, always a fresh face and not the same board members."*
>
> — Focus group participant

Stakeholders also seek more involvement of people with lived experience. They also would like more diverse experience. They would like to hear from

people currently living unsheltered, those in temporary shelters, and those who have moved to permanent housing. They would also like to hear from people representing a wide range of backgrounds and experiences, including veterans, families, youth, people in the LGBTQ+ community, domestic violence survivors, etc.

There is also recognition that in order to support participation, people need to be compensated for their time. Staff from organizations are often paid a salary, so are compensated for their time in meetings and working in collaboration with others. There needs to be equal recognition that people with lived experience need to be compensated to help lift and stabilize them and make them feel valued as contributing members of the community and the CoC.

> *"Many of the programs by the CoC are done online, and not having my own private internet, means I need to use the public internet, at the library."*
>
> — Stakeholder survey respondent

There was also feedback that representation on commissions or committees is not the only way to involve people with lived experience. Indeed, the formality of the settings, and the expectation of regular attendance discourage some people with lived experience from participating. Getting feedback from them on proposed priorities and strategies in more informal settings and creating opportunities for them to play a role on member organizations' Boards of Directors, or on review and rank panels, can create opportunities to integrate their voice into the work for the CoC.

> *"There's a lot of secrecy in the homeless community. People are reluctant to share. Many members fear that if they speak out, they might lose their bed at a shelter."*
>
> — Interviewee

People with lived experience shared that they do not always feel respected and valued for their participation. Some said that many of the CoC meetings are held online, which is hard for people living unsheltered to participate in, as they may not have access to wifi or limited data plans on their phones. There was some movement by the CoC to create more opportunities for people with lived experience to become involved, including purchasing laptops and/or phones that they could use, but that process has not occurred yet. Others shared that they do not feel respected or valued for their experiences.

> *"[I] tried the CoC, as I thought it would be helpful, but that wasn't my experience. People who have more heart than wanting money drop off and go where they won't be ridiculed and where they will be listened to."*
>
> — Interviewee

Recommendations:

1. **Develop a robust orientation, education, and training program** to support new member organizations and individuals, as well as active members, to participate in the CoC
    a. **Conduct introductory trainings** for the new Executive Committee, all Operating Cabinet members, and all Commission members.
        i. Identify staff and delineate their roles and responsibilities for introductory trainings.
        ii. Trainings for all participants should include, at a minimum, basic information about the new governance structure, the roles of each of the different bodies (COEH, Operating Cabinet, Community Intake Center, etc.), and a CoC 101 training.
        iii. Conduct ongoing member orientation to new CoC member organizations and individuals, which should include all the above topics, plus other strategic topics that reflect current activities of the CoC.
        iv. Consider creating a buddy system for new CoC members or individuals to be matched with already active CoC members who can provide context, history, and any other additional information that would help integrate new members into becoming active participants in the CoC.
    b. **Develop a regular and ongoing educational training program** that is available to all CoC members
        i. Identify staff and delineate their roles and responsibilities for ongoing trainings.
        ii. Identify a series of topics that would be most helpful to CoC members, including CoC 101, trauma-informed care, motivational interviewing, Housing First, and other content-rich topics that will be offered regularly to all CoC member organizations and their staff.
        iii. Create a mechanism that allows CoC members to suggest topics for additional education and/or training.
        iv. Establish a regular, predictable schedule for educational trainings that CoC organizations and staff can anticipate and prepare to attend.
        v. Be sure to announce training opportunities a full month in advance to enable front-line staff to build time into their schedules to attend.
            - Ensure that organizations can send as many staff as they desire whenever possible.
            - Consider requiring participation in some training opportunities, based on topic, in order to be a member organization.

2. **Undertake activities to build collaboration and coordination across the CoC.**
    a. Identify activities that can help CoC members get to know one another.
    b. Create structures that enable feedback loops with committees and with individual members.
        i. Learn from organizations that are active members in the CoC how they are sharing information with their teams, especially how they ensure front-line staff are kept informed.
        ii. Consider adopting standard ways in which CoC members are expected to share information about Operating Cabinet meetings with their staff.
    c. Engage more people with lived experience in the activities of the CoC and ensure meaningful participation for those involved in the CoC
        i. Begin to build stronger communication pathways with a broader cross-section of people with lived experience of homelessness and ensure diverse representation on Homeless Caucus and Operating Cabinet, including various subpopulations and those with current or recent lived expertise
        ii. Provide opportunities for those recruited to provide feedback to the CoC and jurisdictions and be involved in policymaking and allocations processes
        iii. Compensate people with lived experience for the time they are preparing for or participating in activities of the CoC (unless they work as staff for an organization that is already compensating them for their time)
        iv. Develop policies within the CoC that set clear and consistent compensation policies
        v. Develop policies that are humane and responsive to the needs of unsheltered individuals and families
            i. Ensure policies reflect the input of those living unsheltered.
            ii. Ensure policies do not criminalize homelessness.
            iii. Work with experts and persons with lived experience on encampment resolution
        vi. Consider delegating CoC members to regularly attend/coordinate attendance at events where individuals experiencing homelessness will be (i.e., weekly donut and coffee hour) to:
            - Communicate about CoC resources and programs
            - Gather feedback, answer questions, seek innovative ideas; and
            - Recruit people with lived experience to be more active in the Homeless Caucus or participate in the Operating Cabinet.
    d. Reach out to new and/or adjacent organizations to introduce them to the CoC and encourage them to join.

3. **Bring more opportunities for engagement to front-line staff**
    a. Bring back Action Camp - monthly meetings used to identify challenges in the system or opportunities for improvement – as they were opportunities for front-line staff to collaborate with others.
    b. Leverage the expertise of front-line staff through key roles in relevant committee work and CoC planning
    c. Survey front-line staff at regular intervals to check in on their level of engagement and ability to participate in CoC activities, including CoC training, committees, and activities
4. **Review the role and responsibilities of the Homeless Caucus**
    a. Formally define the Homeless Caucus within the Governance Charter and ensure diverse representation of sub-populations on the Homeless Caucus.
    b. Make sure that people with recent and current lived experience perspectives are included.
    c. Utilize the Homeless Caucus to bring a diverse lived experience voice to the CoC, including when planning, policymaking, and allocating funding.
    d. Provide staff support to ensure the success of the Homeless Caucus.
    e. Consider compensating those who participate in the Homeless Caucus.

Coordinated Entry

The Coordinated Entry System for the CoC is the Community Intake Center (CIC). The CIC has gone through a number of changes over the years – from a collective case conference approach to the current system, which is organized and led by the United Way, whose team does intake (which is mostly done by telephone) and who has one lead individual making matches and referrals to housing. The current system was conceived to try to eliminate perceived disparities and subjectivity in the former case conferencing process.

> *"Our CIC is so much better than 5 years ago [when] no one spoke to each other, everyone hated each other. People would not share information."*
>
> — Interviewee

While the new system may have eliminated some of the problems from the past, there are now practices and structures in place that prevent the referral and matching process from being as transparent, streamlined, equitable, and effective as it needs to be. There appear to be duplicative steps in the intake and assessment process, multiple and inconsistent VI-SPDAT scores for the same

> *"The response time from the CIC is very slow."*
>
> — Stakeholder survey respondent

individuals, and delays based on an over-emphasis on document-readiness. Another area of concern is the length of time it takes for the CIC to complete intake, assessment and referral. Many stakeholders indicated that the time between intake and referral is far too long for people to be in shelters or living unsheltered. Stakeholders indicated through the survey that they find value in collaborating on assessments during case conferencing. Many survey respondents also indicated that it is difficult for people with lived experience to know where to go to receive a coordinated assessment or to access services through the CoC.

Intake and Assessment

The CoC's intake and assessment process is multi-layered. While intake can occur at many access points throughout the homeless system of care, the intake and assessment process at those access points is not uniform or standardized. In addition to the intake done at one of many access points, as the CIC, the United Way has an additional layer that their staff perform once an external intake comes to them.

> *"Programs do [Vi-SPDAT assessments]. United Way does them if there are outliers of people not connected to a service. Every access point does the VI-SPDAT at initial intake and within two-weeks. It is all stored in HMIS. Some of the access points will do it during initial intake, others will do it two weeks later once they have case conferencing."*
>
> — Interviewee

Some individuals are required to go through multiple intakes: one at the shelter or through the street outreach team, and then two to three with the United Way's internal team. After intake, the client must go through a more in-depth assessment, asking additional personal questions. The duplicative and repeated intake and assessment process can be burdensome and traumatizing to clients, repeating their personal history several times unnecessarily.

> *"Tried CIC but people just don't respond, too much paperwork – just spitting in the wind."*
>
> — Interviewee

In HMIS, individuals often have multiple assessments and VI-SPDAT scores, and it is not clear which data is used for prioritization, matching and referral. In some cases, clients have 20 or 30 VI-SPDAT scores within a relatively short timeframe, and they vary widely from low (scores that would suggest diversion only) to high (scores that would match to permanent supportive housing). It is difficult for the Collaborative Applicant or local programs to use HMIS to understand client needs and system

> *"There are a lot of people outside that are not connected to intake and a lot of people who are not on the BNL."*
>
> — Focus group participant

performance when there is such a variety of entries and scores for the same individuals as it is challenging to differentiate amongst the scores to know which one is the most accurate. It also provides some concern about the calibration of the assessment CoC-wide and suggests a need for training, evaluation, and potential system redesign.

It is also unclear whether there is a uniform and consistent understanding of diversion across the organizations who do intake. Some stakeholders believe that even people with high barriers can be candidates for diversion, but their understanding is that, in practice, only people with little or no barriers are being diverted.

> *"Because we handle a special population, we have been doing our own stuff simply because it is easier. It's reducing the length of referral time. It sems like it passes 2-3 hands before the client gets to our organization. We have had conversations with shelters and other people. We do our own VI-SPADT assessment and enter the information in HMIS and then just take it from there. I remember going through the whole BNL and just going by the assessment number and not discussing urgent need. I think it would be helpful to understand the whole process the CIC is involved in. Is there a CIC manual that can be made available – a workflow chart, one page that says this is what happens, this is how long it generally takes. I didn't know there was another layer to getting a person housed. I assumed everyone gets assigned a case manager. My understanding with the referral process, referral and then one person at UW gets it, and then another person at United Way has a part and then another person at United Way is involved and then it comes to the [partner organizations.]"*
>
> — Focus group participant

Referrals and Matching Process

The current referral and matching process is done by one individual at the United Way. They are not able to pull a comprehensive by-name-list (BNL) from HMIS, because not all service providers are allowed to enter client data into HMIS, so a separate list is collected from that provider. While all other providers enter their data into HMIS, United Way staff must use an Excel spreadsheet to keep track of that other provider and use the combination of the HMIS and Excel to make matches and referrals. As a result, a complete BNL is not accessible to others, including the Collaborative Applicant.

There are other challenges around the BNL. It was originally set up by OrgCode, which designed the VI-SPDAT assessment, to pull the necessary data and compile it into one list based on the CoC's prioritization criteria. However, neither the HMIS Lead or CIC Lead can alter that programming in any way. The list can be pulled as is along with a couple of sub-population lists, but searches based on various criteria, such as housing type/size and sub-population to fit a

certain opening cannot be done. These limitations make it difficult to make matches and referrals for specific opportunities to arise or to analyze the need within the community at any given time.

Another concern frequently mentioned is that the CIC Lead will not share the existing BNL with the CoC Lead or providers as they consider that private information. However, in most communities, the de-identified BNL is part of the work of the CoC and is necessary information used to understand the system and individual clients. The lack of transparency in the BNL means that service providers and case managers cannot locate their clients to find out what VI-SPDAT score is being used for prioritization nor can they learn where their clients are placed on the BNL. Further, it makes it difficult for planning purposes for agencies and committees.

> "Even with the VI-SPDAT score. Can't see some of the scores and they are supposed to be visible in the files."
>
> — Focus group participant

Because there are multiple intakes and assessments of individuals made at different times in the system, by different providers, it is difficult to discern which VI-SPDAT score the United Way staff is using for referrals and matches. An initial perusal of individuals and their VI-SPDAT scores in HMIS showed a wide range of scores for people eligible for RRH and PSH – some scoring as low as a 2 at one point in the assessment process.

> *"There are also a lot of people who are never touched because they are scored too low. Some self-resolve but some are in the middle and have barriers."*
>
> — Focus group participant

According to numbers provided by the United Way in the Coordinated Entry Annual Evaluation for July 2020-June 2021 and for this assessment, the average number of people on the BNL remained fairly steady between 2018-2019 (641) and 2020-2021 (603).[6] At the same time, the number of households reported on the BNL went down sharply between 2018-2019 (484) and 2020-2021 (272), a 44% decrease. It is not clear why the number of people remain similar and the number of households would

> "It takes a long time for my clients. I don't really get to discuss some of the residents' cases. Their scores are lower or they are children. I have to wait awhile before one or two even come up on the BNL. I don't know when they are going to do intake with them, I just get an email. I have no type of information about the programs, I have not received a response for that when I've raised it. There is time limit between intake and when they get a case manager. I have no information that isn't basic to share with [my client]. When I ask for that, I send emails and I don't get responses.
>
> — Focus group participant

[6] Source: Coordinated Entry Annual Evaluation July 2020- June 2021, The United Way.

drop so significantly. One factor could be that household sizes increased. However, other data on households (HMIS and PIT) did not align with such a significant increase in household or family sizes during that period of time. Additional analysis is needed to better understand this reported CIC data.

Also changing between 2018-2019 and 2020-2021, as identified in the Coordinated Entry Annual Evaluation, were the number of matches and referrals to RRH and PSH. The number of total program matches made between 2018-2019 (296) and 2020-2021 (171) went down by 42%. The number of total referrals to RRH and PSH also went down during the same period by 37%. In 2018-2019, the CIC made 228 RRH referrals and 51 PSH referrals and for 2020-2021, it made only 151 RRH referrals (34% decrease) and 20 PSH referrals (61% decrease).[7]

Case conferences are still held by the CIC, but they are convened to discuss the management of complex cases served by multiple providers or that need a variety of services. The case conferences are collaborative and bring together different providers. However, the case conferences are not part of the matching and referral process. The matching and referrals for the harder to place clients are done separately like the others by one individual at the United Way using the BNL that they create.

> *"As an outside provider who is working with a homeless client, we are not able to attend the CIC meetings. Not a team or community approach."*
>
> — Stakeholder survey respondent

The lack of case conferencing for every individual was raised as a concern. Some stakeholders felt that the process focused far too much on the VI-SPDAT score and did not allow the community to collectively share information they have about clients and their abilities and capabilities. As one stakeholder survey respondent shared, "The system may be equitable, but it is not always fair. Focusing only on numbers sometimes means people will fall through the cracks." A more holistic approach to assessment, matching and referral that focused on equity was a desire for many who participated in the process.

> *"I would like a pamphlet describing what programs are available. Everyone who comes in is supposed to get RRH – that doesn't happen. For me to present, people would like to see something on paper. There is only what I know from the program and what I tell them – I have no time limit when they will receive the assistance and some of them don't get anything when they have to move out of the shelter – some of them wait 3-4 months."*
>
> — Focus group participant

[7] Coordinated Entry Annual Evaluation, Ibid.

Document readiness

The topic of document-readiness came up in most interviews and focus groups. It was clear that the community is frustrated with the approach to helping clients gather the paperwork they need to be eligible for permanent housing. This frustration appears to stem from a lack of clarity around process, roles, and timing, as well as an over-emphasis on document readiness that at times prevents the provision of other necessary services.

Most stakeholders asserted that it is unclear who is responsible for helping people prepare and collect all the documents they need to be approved by a program, landlord or property manager for housing. Many people we talked to felt that this was or should be the responsibility of another entity within the system. There is not an effective or well understood procedure in place at this time. As a result, it appears that this can end up as a barrier for individuals in need of housing and can extend their waiting times as well create barriers to utilizing all available housing in the CoC.

> *"Don't require documents as a shelter, so not an issue. [The shelter does] help people get DMV and birth certificates, etc. but we hear from a lot of case managers that [lack of documents] is a barrier. They do help people get free identification, but it is a barrier for guests. Many guests have traumatic brain injuries, mental health issues, etc. The CoC could provide peer support and other programs to help clients obtain necessary documentation."*
>
> — Focus group participant

> *"It used to be when received the key documents that all documents would come along in hard copy. It isn't happening like it should be anymore."*
>
> — Interviewee

The National Alliance to End Homelessness (NAEH) has been evaluating and providing support to the Continuum of Care to help improve the shelter and housing system. One of their findings

Housing First is a national best practice that eliminates barriers to housing, ensuring individuals and families can exit homelessness as quickly as possible. Under a Housing First approach, people experiencing homelessness are supported in returning to housing as quickly as possible, often through supportive housing programs that have no pre-requisites, preconditions, or program participation requirements. Supportive services are offered on a voluntary basis to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

The Housing First approach has been extremely successful in reducing the length of time households are homeless, preventing returns to homelessness, and supporting participants' long-term stability and well-being. Research suggests Housing First program participants are 2.5 times more likely to be housed after 18-24 months than other programs.

Multiple studies show that Housing First significantly reduces the costs of homelessness on communities.

was that the emphasis on document readiness and the way that it is implemented locally is contrary to low-barrier and Housing First principles.

Fundamentally, Housing First is a national best practice that eliminates barriers to housing, ensuring individuals and families can exit homelessness as quickly as possible.

If you condition shelter and housing opportunities, even when someone is in crisis or is at the top of your BNL, on documentation that you have not provided the necessary supports to obtain, then you are creating systemic barriers that will undermine individual and household success as well as overall system performance.

> *"Within 48-72 hours are expected to make contact and can do that, be we cannot do the intake into RRH w/out all documents."*
>
> — Focus group participant

By creating a clear consistent procedure for how to assist people in obtaining documentation that can apply once people are stabilized in shelter or through supportive outreach, individuals will not lose out on housing opportunities when they become available. If matched, documentation should not be the barrier to permanent housing opportunities, especially when the challenges relate to systemic failures and lack of opportunity.

As discussed, helping people prepare their paperwork so they can be eligible for housing is important; however, there are many other important services that should be offered while people are awaiting a housing placement, including housing navigation, life skills training, assistance with job search or placement, making referrals for mental and physical health care services and more. Instituting a clear system will allow for an expanded focus to ensure a more holistic approach to individual care that does not currently exist.

In the CoC, most referrals and matches are for RRH, which requires staff to connect with private landlords or property managers and share significant paperwork about their clients. Yet many of those clients are likely in need of permanent housing along with longer-term supportive services through PSH. The burden to be document-ready is much more reduced in PSH (documentation of disability and chronicity). Because many people eligible for PSH are being referred for RRH, a substantial amount of time preparing documents for those individuals is being wasted.

Recommendations:

This Assessment looked at the many functions, providers, and processes involved in the CoC. It did not, however, include a deep dive into the data and processes of the Community Intake Center. While we were able to identify challenges and barriers through limited data analysis

and stakeholder engagement, a more thorough evaluation of the Coordinated Entry System is required to make concrete recommendations to the CoC.

To guide the CoC, we could recommend the following:

1. **Contract with a third-party expert to evaluate and improve the effectiveness of the Coordinated Entry System**[8]
    a. **Identify financial resources available** from either the CoC, the City, and/or the County that can be used to conduct a deep and thorough evaluation of the Community Intake Center processes and policies.
    b. **Identify a committee** of 3-5 CoC members who will represent the CoC to develop the RFP, evaluate applications, and advise expert/s once they are engaged. The committee should be responsible for ensuring that the process includes:
        i. An evaluation of the system's assessment, prioritization, referral, and placement processes.
        ii. An evaluation of housing outcomes.
        iii. An evaluation of the timeliness of referrals and matches, as well as offering of supportive services.
        iv. Focus on the system itself and its functioning, and how well it has streamlined access, assessment, and referral processes for housing and other services.
        v. An assessment of the Community Intake Center for fidelity to local policies and compliance with HUD requirements.
        vi. An evaluation of implementation and operation in accordance with locally established policies and procedures.
    c. **Develop an RFP that identifies expectations and best practices** for a CES evaluation. The scope of the RFP should address the following:
        i. How can the CIC improve user experience and increase participant movement out of homelessness to housing?
        ii. Is the Community Intake Center compliant with HUD's requirements and if it is not, what changes need to be made?
        iii. How effective is the Community Intake Center process in connecting people experiencing homelessness to appropriate referrals (exploring system need, time to referral, referral appropriateness, and referral outcomes)?
        iv. How effective is the CIC in diverting households from homelessness through referrals to homelessness prevention and community resources?

[8] HUD guidelines prohibit Coordinated Entry evaluation to be conducted by the Coordinated Entry management entity. See, Coordinated Entry Management and Data Guide, U.S. Department of Housing and Urban Development, pages 4 and 12.

v. Has the Community Intake Center process been implemented, and is It currently operating as intended and in accordance with the CoC's policies and procedures?
vi. Do the system entry points adequately cover the full geographic area of the CoC?
vii. Are clients able to access the CIC?
viii. Are CIC staff able to effectively determine client needs during assessment(s)?
ix. What is the distribution of assessment scores for each of the assessment types for clients (single adults, families, youth/TAY)?
x. What information is missing from the assessment and/or the centralized waiting list that would better help inform matchers of client needs?

2. **Consider incorporating into a CES evaluation review of the assessment process and alternatives to the VI-SPDAT** that are more holistic and equitable.
    a. Review alternatives to the VI-SPDAT with a community-specific, more holistic, assessment process.
    b. Replace the existing BNL process to increase flexibility, transparency, accuracy and collaboration.

Shelter and Housing

There is no question that there is not enough affordable housing available in Winston-Salem / Forsyth County. But in addition to the lack of affordable housing, there is also an insufficient number of beds available for temporary housing (e.g., emergency shelter beds). Based on the Housing Inventory Count (HIC) for the CoC, there has been a decrease in available beds overall between 2015 and 2022.

Because of the American Rescue Plan Act (ARPA), funding was made available for special Emergency Housing Vouchers (EHVs), which are Housing Choice vouchers dedicated to people experiencing homelessness or at-risk of homelessness, fleeing, or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking, or were recently homeless or who have a high risk of housing instability. Because of the addition of the EHVs to the CoC, the number of permanent housing opportunities in Forsyth County has increased, especially between 2021 and 2022, by 97 new beds. Overall, the change in availability of beds in Forsyth County includes:

- 27% decrease in overall beds since 2015
- 15% increase in permanent beds since 2015 (due to EHVs)
- 53% decrease in temporary beds since 2015

The total beds available for people experiencing homelessness declined by 216 beds between 2015 and 2022. That is an average of almost a 20% decline.

Bed Type	2015	2022	Number Change	Percent Change
ES	447	236	-211	**-47%**
TH	126	33	-93	**-74%**
Total temporary	**573**	**269**	**-304**	**-53%**
RRH	103	216	113	**110%**
PSH	494	372	-122	**-25%**
EHV	n/a	97	97	**100%**
Total permanent	**597**	**685**	**88**	**15%**
Total	**1170**	**954**	**-216**	**-18%**

Rapid Rehousing and Permanent Supportive Housing

Rapid rehousing (RRH) has increased substantially (109%) over the past 6-7 years while all other types of temporary and permanent housing have gone down (except for the one-time ARPA-funded EHV beds). While an increase in any type of housing, including RRH, can be useful for the CoC, the program is not intended for everyone experiencing homelessness.

Stakeholders shared that a disproportionate number of people are being matched and referred with RRH. RRH is intended for people experiencing homelessness who need short-term support (for most funding streams it is a maximum of 24 months of rental subsidy and supportive services with up to 6 months of retention case management afterwards). Numerous stakeholders felt that people were being referred into RRH who should be in permanent supportive housing (PSH), which provides longer-term support to assist households with at least one member (adult or child) with a disability in achieving housing stability. One stakeholder shared that they think this misplacement occurs “80% of the time.” Other stakeholders felt that clients assessed and matched with RRH who need the longer term supports that are associated

with PSH are being denied the help and support they may need, risking a return to homelessness, and potentially damaging landlord relationships when people are not able to retain their housing units. During our RRH focus group, one stakeholder shared that they received referrals of more than twenty households for RRH, all of whom should have been in PSH.

> *"When we were focusing on the [encampment], we took all the individuals and we had money as a community to put them in a hotel-type shelter. We took those folks and moved them into RRH, 100% of them. We called the shelter medically fragile – and I think 100% of them needed PSH and they were all in RRH."*
>
> — Focus group participant

Based on stakeholder feedback and review of the data and policies and procedures of the CoC, RRH may be used for purposes contrary to the intended purposes of the program. While policies and procedures of the CoC define RRH as a short-term program (0-24 months), other policies suggest evaluating RRH recipients at the one-year mark. A deeper dive into the Coordinated Entry policies and practices is needed to determine if some households participating in RRH that are unable to successfully complete the program within one year are being evaluated through case conferencing and provided additional supports and/or reassessed and returned to the BNL prioritization list to be considered for PSH.

> "Several of them have been referred for RRH go back on the BNL because they cannot manage their lives, health issues, don't have the finances to maintain anything. And there are some who have returned to the BNL – their scores are not as high as people receiving outreach, the likelihood of them getting a voucher might not happen."
>
> — Focus group participant

In 2021, more than 65% of the funding requested from HUD for the CoC ($2 million) was used for expansion of RRH projects ($1 million was for funding PSH). In contrast, North Carolina statewide HUD funding requests for RRH expansion averaged approximately 15%. RRH programs are highly dependent on the private market for success (i.e., landlords and property managers must be willing to rent to people experiencing homelessness). At the same time, the rental market In Winston-Salem has

> *"I was on a call/meeting out west where they are doing tiny houses. Would love to explore that. Especially since we are having housing challenges. They threw around shared housing a lot but haven't heard as much about that. [We need to] be more forward thinking. Out of the box with housing.*
>
> — Focus group participant

become highly competitive (for the last quarter of 2020, the rental market vacancy rate was only 7.1%)[9].

Only a small percent of matches and referrals in the CoC are made to PSH. Placements in PSH through the CIC went down between 2015 and 2022. Between 2019 and 2020, the number of referrals to PSH went down a full 71%. Stakeholders indicated that the PSH program used to function well, but not only are referrals not being made, but their understanding was that there are empty PSH beds while 600+ individuals wait for housing placement.

> *"Housing prioritization isn't equitable - folks that aren't ready for housing are pushed through the system without true support on the backend and end up with evictions. Lately it hasn't made sense as to how the vouchers are assigned - folks that seem like RRH would be the better option are getting PSH and folks whose only/best housing option would be PSH are getting RRH."*
>
> — Stakeholder survey respondent

Another issue that stakeholders raised was the role of case managers in RRH and PSH placements. Some said that case managers who work with RRH-eligible households are not allowed to also work with households in need of PSH. Others shared that PSH case managers feel that they have sufficient capacity and are able and willing to take on those cases but are not getting those referrals. (See further discussion on case management and capacity issues, under Services, pages 47-48.)

In the community's 2018 strategic plan, the CoC committed to expanding PSH, yet that has not occurred. It is unclear the root causes of the decrease in PSH. Are people being assessed fairly and accurately for PSH eligibility? Are people assessed for PSH but referred to RRH? Is there a lack of case managers able to provide support to people eligible for PSH? Are people placed in PSH not getting the services they need to be able to move to permanent housing without supports, thus preventing those beds from being available for new individuals? A closer look at the Coordinated Entry System will help the CoC determine the cause/s and be able to adopt strategies and policies to address those causes.

As part of the community engagement process, we heard from stakeholders that they felt that there was not sufficient expertise on housing in the CoC, particularly leadership on PSH. Some stakeholders shared that when they ask more detailed questions about housing, CoC staff cannot always answer, and the issues often remains unresolved.

[9] Comprehensive Housing Market Analysis, Winston-Salem North Carolina, U.S. Department of Housing and Urban Development, Office of Policy Development and Research, January 2021.

Housing First

Another area that came up regarding housing and shelter was the way the CoC approaches the Housing First philosophy introduced above. We heard from stakeholders that there are some CoC organizations and programs that are not really committed to implementing a low-barrier, Housing First CoC. Some people felt that organizations say they are Housing First to access CoC funding, but in practice they are not implementing the Housing First philosophy and lowering barriers.

Most supportive services provided under the auspices of the CoC case managers focus on getting people document ready. People are not eligible for housing while the documents are being gathered. Many stakeholders shared that it takes a long time before people are eligible for housing placement. The confusion within the CoC on who is responsible for helping prepare documents only exacerbates the issue.

> *"Housing is not available for the right people at the right time. We give lip service to lowering barriers but the system itself is inherently complicated and difficult to navigate."*
>
> — Stakeholder survey respondent

There were many stakeholders who shared that there is a big difference in terms of the policies and practices of the local shelters. People with lived experienced and service providers both shared that many people do not want to go or do not feel welcome at some of the shelters because of their rules and practices. Others shared that some individuals experiencing homelessness have been banned from some of the shelters because they have not followed the complex rules, many of which are not related to the safety and security of the staff or residents. Some shelters require things like lengthy intakes (over 50 pages of documents), multiple intake/assessments, and specific documentation to enter making it difficult for those with mental or physical illness or without documentation or experiencing a crisis to enter despite the fact that they may be the most in need.

> *"Affordable housing is one of the issues where there is a lot of talk, and little action. Mold and mildew grow at a faster rate of speed than any discernible results, can be noticed."*
>
> — Stakeholder survey respondent

Emphasizing document-readiness also results in long periods of wait time; people are in temporary shelter, unable to move to permanent housing (or even get prioritized) because not all of their documents are ready. The length of time people who are homeless in emergency shelter, safe haven or transitional housing grew by 20% between 2015 (87 days) and 2021 (104) days.

"We've said our goal is housing within thirty days. If we could process the paperwork faster, we could get people housed faster. Someone in outreach might do it well, but others might not. So we might get referrals where there's not anything. We'll do it ourselves, but it takes time, and that makes it hard to meet the 30 days."

— Interviewee

Recommendations for Shelter and Housing:

1. **Identify either an internal expert from within the CoC or 3rd party expert on permanent supportive housing (PSH**) who can play a leadership role in the CoC and Operating Cabinet and who can be relied upon by other CoC members for information, advice, and support about development and operation of PSH in the community.
2. **Review and revise policies and procedures around housing placement** to ensure that individuals and households are being appropriately matched and referred to housing that fits their needs.
3. **Set CoC-wide goals to reduce the returns to homelessness**, to help ensure people are placed in appropriate permanent housing and are receiving the supportive services they need to retain stable housing.
4. **Review Housing First policies and protocols** and revise them to expand the supportive services available to people awaiting housing placements beyond document readiness.
    a. **Develop monitoring protocols** that are implemented at least quarterly, to ensure all CoC members are implementing and practicing low-barrier, Housing First policies and procedures
    b. **Conduct a training or series of trainings on Housing First** for all Community Intake Center staff, CoC members, shelter staff, front-line staff, and any other individuals and organizations participating in intake, assessment, and service provisions.
        i. Bring in staff from other CoCs (neighboring jurisdictions or communities of a similar size/demographic) who can share how they provide extensive supportive services while people are awaiting housing placements, while still helping people get document ready.
        ii. Evaluate shelters that already exist to identify the barriers to entry and the rules for participation. Offer training and technical assistance to those shelters on how to become low-barrier and transition to a Housing First model.

Services

Offering supportive services – case management, help with independent living skills, assistance locating available and affordable housing, referrals and connections to mainstream benefits, mental health and substance use treatment, job training and employment searches – is a fundamental responsibility for the CoC. Stakeholders in one-on-one interviews and in focus groups and at community meetings shared that the supportive services most often offered to clients were case management and assistance with collecting paperwork. The community expressed concern that there was not an abundance of other supportive services offered through the CoC. In some cases, the lack of services was due to the lack of availability in the community – a prime example of that was mental health services. In other cases, the lack of supportive services may be related to all the resources expended helping clients become document ready.

> *"There seems to be services provided for individuals mainly at one homeless shelter and people with disabling conditions that have income or very little assistance are often overlooked."*
>
> — Stakeholder survey respondent

Case management

Many stakeholders raised concerns with the current system of case management. They shared that there are not enough case managers and even for the ones who are working with the CoC, restrictions on caseload levels and who they can help and/or what program types they can work on limit the number of people they can help.

One of the biggest issues raised was the protocol that limits caseloads per case manager. While there is no official policy about a caseload limit, we heard the cap to range anywhere between 20 and 25 cases per case manager. The limit includes support for people who are currently homeless and people who are stably housed who need less ongoing case management. It is valuable that the CoC recognizes the need to continue case managing even after someone receives housing. However, the level of need for someone housed is much lower than someone who is temporarily housed in an emergency shelter or unsheltered and still living outdoors. A

> *"We need services that leave their offices and meet people where they are other than outreach staff! Case management from behind a desk is pretty much worthless and outreach without access to housing and services to connect people to is also pretty much pointless! We are great at finding people and identifying their needs and creating long lists of people who are not getting the help they need."*
>
> — Community survey respondent

caseload of 20 individuals who are unsheltered or temporarily housed is more time consuming than a caseload that includes people who are in RRH or PSH. As a regular practice, people housed remain on a case manager's caseload for up to two years after they obtain housing as case managers provide help to retain housing. However, given the specific 20-case maximum, having these lighter lift households still prevents case managers from having room to take on new individuals and families.

For case management services of people who are not housed, efforts to prepare documents for landlords (RRH) and to certify disability or chronic homelessness (PSH) seemed to be happening with case managers at all different stages in many different organizations. We did not hear much else about other services people receive while awaiting housing placement. For people who need assistance accessing mainstream benefits, such as Medicaid, SNAP, or TANF, there is not a central or coordinated way for them to do so.

> *"I have asked repeatedly for employment assistance but received nothing substantial, consistent, or sustaining."*
>
> — Interviewee

Once people have their documents and are on the by-name-list, not all stakeholders were confident that people were receiving case management and other supportive services while they were awaiting housing placement – supportive services such as life skills training, job training or employment assistance, resume building, etc.

> *"I recently learned other NC counties are giving signing bonuses to landlords; have risk mitigation funds; rental rehab programs, and a liaison between landlords and CoC. If CoC and provider agencies cannot solve case management issue, need to work with other providers who are proving CM to mutual clients."*
>
> — Stakeholder survey respondent

Stabilization

Another issue that came up repeatedly through the community engagement process was the high number of people returning to the system and challenges with helping people stabilize once they are housed. Not all stakeholders understand what services, in addition to case management, are offered to people once they are in RRH or PSH. Folks want to see true wrap-around services provided to support people long-term, including mental health and substance use treatment services. One stakeholder survey

> *"House them, house them, house them, but there aren't adequate supports. Landlords are tired of being burned by RRH. They are coming back and back."*
>
> — Focus group participant

respondent shared that “relationships are important, as well as medication and assessment.”

Stakeholders raised concerns about the dearth of mental health services available in the community. They seek engaging and available mental health services that are accessible (e.g., easy to get to via public transportation and with little to no wait times) to people in shelters and people living unsheltered. Currently, there are limited mental health services offered, including one day per week on site at three of the local shelters. These services are provided by psychiatrists, one of whom is also certified to evaluate and work with clients with substance use disorders. There are few additional mental health services beyond the limited services offered onsite at the shelters.

> *“One of the weak links in the chain of the CoC is mental health. One of the links that would get people housed faster and sooner would be mental health [services].”*
>
> — Interviewee

A number of stakeholders brought up the concern that there may not be consistency in the way staff communicate with clients about their pathway forward, expectations, and opportunities. There are many clients with mental health issues who can live independently with community supports, yet staff indicated that the lack of mental health offerings meant that people often go without the supportive services they need to remain stably housed. In addition to mental health and substance use disorder services, we also heard from stakeholders that there is a need for more job training and employment assistance for people experiencing homelessness to help them obtain and retain jobs so they can afford long-term housing.

Populations served

The CoC has to deal with the impacts of the disparities that exist in the homeless system of care compared to the general population in Forsyth County. Race and ethnicity data from the Point-in-Time (PIT) count compared to the general population indicates that Black individuals are significantly overrepresented in the homeless population, while whites and Hispanics/Latinos are underrepresented. (Figure 4, page 9) While 27.5% of the general population in Forsyth County identifies as Black, 51% of the homeless population identifies as Black, almost two times more likely to be homeless.

At the same time, while 13% of the general population in Forsyth County identifies as Hispanic/Latino, only 3% of people experiencing homelessness identified through the CoC’s annual PIT count as Hispanic/Latino, (Figure 5, page 9) This suggests that the Hispanic/Latino community that is experiencing homelessness may not be connecting with the CoC. Some stakeholders felt that the community was insular

> *“What about Hispanic population? Are they not homeless, or are we just not reaching them?”*
>
> — Interviewee

and being supported outside the CoC system, while others felt that the CoC does not have sufficient staff who come from the Hispanic/Latino community or who are bilingual who would make people feel welcome from that community.

> *"Because of the Hispanic community where they help each other [we] don't see many Hispanic clients. We see a few who come eat at the soup kitchen. Have suggested that the CoC set up a table and be that in between and translate and help bridge that gap and identify their needs. There are some families and single men. Would be great to find out what their needs are."*
>
> — Focus group participant

Another population that stakeholders felt were not getting the support and services that were needed were people with behavioral health issues, such as substance use or mental health disorders. The number of people experiencing homelessness with mental health and/or substance use disorders increased from 2020 to 2021 (by 342% for mental health and 228% for substance use). The sharp increases occurred at a time when PSH bed availability was at its lowest since at least 2015. The number of chronically homeless individuals in the CE system also increased dramatically between 2019 and 2021 (by 207%)

> *"All populations need to be treated equally. This includes recovering substance abusers, unemployed, and those dealing with physical and mental disorders."*
>
> — Stakeholder survey respondent

> *"I do think we need as a community to have better "mainstream" service access for people who are homeless. Just because someone is homelessness doesn't mean they should get their mental health treatment in a specialized program just for homeless people. The mental health system should develop interventions that serve homeless people. I believe that the homeless service system should work on getting people housed and as a part of their housing stability should be supported in accessing other necessary services from providers who specialize in those services."*
>
> — Community survey respondent

Stakeholders raised concerns that other populations are not fully supported through the CoC. Another example was individuals re-entering the community from the criminal legal system. Stakeholders said that the CoC had identified the need to work specifically with people re-entering

> *"Need training of homeless CoC staff in mental health and substance use disorders; de-escalation skills [and] simulations of how difficult the process is to obtain housing and needed services."*
>
> — Stakeholder survey respondent

homelessness from incarceration settings and had set up a workgroup or committee, but that the committee was led by an intern and the work had not moved forward.

Additionally, there is little, if anything, available through the CoC for youth, older adults, LGBTQ+ individuals, and Latinos. Stakeholders noted that there has been a lack of housing for older adults and a large increase in unsheltered homeless youth. (The percent of homeless youth who were living unsheltered was 5% in 2015 and by 2021 it was 48%.)

> *"Progress is being made, but there needs to be more focused attention on trauma -- the trauma people experiencing homelessness have/have had, the trauma service providers have experienced in their lives and the trauma service providers experience as part of their work. We learned through COVID that some need more individual care as they are waiting for housing (medically fragile hotel). Can we figure out better ways to support people even in shelter?"*
>
> —Stakeholder survey respondent

Recommendations:

Based on extensive stakeholder feedback and community engagement, Homebase recommends the following:

1. **Review and revise case manager requirements**
    a. **Revise caseload requirements and caps for case managers** that allow for more individuals and households to have case managers and for utilization of additional housing opportunities in the CoC.
    b. **Review and revise, if necessary, policies and procedures** to allow case managers to serve people awaiting placement in both RRH and PSH, even if the funding sources are separate so long as accurate recordkeeping is in place.
2. **Streamline how the CoC helps people become document ready**
    a. **Adopt a clear, understandable, consistent policy/protocol about how to establish documentation,** including when, how, with/from whom.
    b. **Partner with mainstream benefit program providers** to assist with document readiness
        i. Consider bi-monthly document readiness fairs that include CoC members, mainstream provider agencies (e.g., Social Security, DMV, Medicaid, SNAP, TANF), where individuals experiencing homelessness can obtain assistance in a centralized location to get documents necessary to obtain permanent housing (i.e., birth certificates, identification, social security cards)
3. **Create client portfolios for the client to help improve access to RRH.**

   a. Include letters of support from community members who know the individual or family or add information about their background and the steps they have taken to improve their housing stability.
   b. Help individuals with criminal record expungement, credit repair, and eviction expungement, if needed.
   c. Provide opportunities for potential tenants to meet landlords one-on-one to create personal connections.
4. **Review Housing First policies and protocols** and revise them to expand the supportive services available to people awaiting housing placements beyond document readiness. (See full set of recommendations above in Shelter and Housing.
5. **Focus resources on hiring and training staff to better serve special sub-populations** whose needs are not currently being met by the CoC, including the Latino community, older adults, youth, and LGBTQ+ individuals
   a. **Build capacity and support to the Latino Community**
      i. Work to hire more bi-lingual staff across the CoC member organizations
      ii. Conduct outreach to organizations that primarily serve the Latino community to better understand the needs and ways to engage to provide more support, services, and access to housing for Latinos.
   b. **Conduct outreach to organizations primarily serving youth, older adults, and LGBTQ+ individuals** to better understand their unique needs, uncover the reasons behind their lack of participation in the CoC, and to collaborate with them to become more involved and active in the CoC.

Data

The overall number of people experiencing homelessness in 2021 was roughly down to pre-pandemic levels – an accomplishment given the disruptions of COVID. Unfortunately, there is a growing number of people experiencing unsheltered homelessness. PIT data from 2021 (the most recent unsheltered PIT count) indicates the number of people living unsheltered has increased significantly since 2015 (22 in 2015 and 139 in 2021) while the number of people sheltered has gone down (549 in 2015 to 323 in 2021). PIT data shows that unsheltered people comprised 4% of the homeless population in 2015 and now comprise 30% of the population. Additionally, the average length of time homeless has been trending upward since 2018; in 2021, it was the highest it has been since at least 2015. Additionally, returns to homelessness are high and trending upward for street outreach (though trending downward for emergency shelter).

During the CoC Assessment, we identified three specific areas related to data that could be improved:

- HMIS functionality/ease of use
- Quality of data
- Use of data

HMIS functionality

The CoC shares an HMIS system vendor with other CoCs in the state of North Carolina. The system is set-up generally to work for all the CoCs and is not customized by the vendor for Winston-Salem/Forsyth County's CoC. As the HMIS Lead, the City can do some customization to the system, including custom intake and report design. There are some existing limitations with the system, especially as it relates to the Coordinated Entry set up at this time.

The current BNL design does not allow the CoC to pull key information about people in need of shelter and services to be able to do comprehensive match and referrals. For example, if the CIC lead who does referrals and matches learns of a RRH opportunity appropriate for a family, they cannot use the existing BNL in HMIS to narrow the results by household or by specific questions to determine the ones at the top of the prioritization list who are waiting for housing placement.

> *"[HMIS] is somewhat limiting – we would love to have a new BNL that better serves us. It has not changed since 2017). We can't filter by household, just by service provider, referral, HMIS #, age, date of birth, provider, family, veteran. [We] can't filter by questions. Some columns are written as 'match date' and 'housed date,' but they don't accurately work. House date stays there forever. [We] can't get rid of those and people stay in there."*
>
> — Interviewee

The HMIS was deliberately designed as a closed system, which means that HMIS users only have access to their own data and not that of other agencies or of the system as a whole. The collective group of CoCs went through a process to develop a new statewide HMIS. They were looking for a model to allow local communities to be the drivers. Stakeholders shared that there are pros and cons to the current system. The local community has been very cautiously building the ability to use the data that they collect. Some stakeholders feel like they have high quality data.

As a generic HMIS that is intended to work well for all the CoCs who participate, the functionality of HMIS is limited. It can be somewhat difficult to customize it to work better for Winston-Salem and Forsyth County.

As discussed, the primary outreach provider does not use HMIS due to HIPPA concerns. As a result, a large percentage of people experiencing unsheltered homelessness are not in HMIS,

and many of the individuals and households who are eligible for housing are not reliably and transparently tracked.

During the stakeholder interviews, we heard from some partners who do not use HMIS at all. It is not because they are prohibited, but mostly because it is not efficient to use the system as it currently functions. There is some question whether organizations serving families are using HMIS to enter assessment data to make matches, or they are matching informally with the use of HMIS and the matching/referral process. We know that some partners are frustrated with how long it takes for people to go through multiple layers of intake and assessment and waiting far too long for housing placement. (A comprehensive CE evaluation will help identify the facts.)

In addition to family status, there is also no way in the current BNL in the HMIS to sort by people who identify as LGBTQ+ and/or who speak Spanish. Without additional analyses of HMIS and CE, it is hard to discern the extent of the problems and whether changes in both the CIC and HMIS systems need to made.

Quality of data

For this assessment, HMIS data for a recent three-year period was reviewed and data quality issues were found. Many of the HUD-required universal data elements (UDE), that all HMIS-participating CoC projects must complete, were missing. It is unclear whether it is because they are data fields that the local partners do not regularly access, that the partners are not aware that those fields need to be completed, or if the partners are simply not completing fields. (A full comprehensive CE evaluation will help to understand the facts.)

Other data in HMIS raised questions. We looked at data for CE and various VI-SPDAT scores for 581 people, but when taking out duplicates, the data represented less than 200 distinct people in HMIS. It turned out that some of those individuals had touched the CE System over 30 to 40 times with accompanying assessments and, at times, over 30 different VI-SPDAT scores. It is a best practice to do a new assessment if a significant change occurs for an individual or household that may impact their level of need. However, it seems unlikely that the frequency of the assessments and accompanying VI-SPDAT scoring, which at times occurred in close proximity to each other, was always due to household changes and subsequent updates.

There is a need to do a full and comprehensive CE evaluation to understand some of the additional issues that surfaced during the CoC Assessment, including the following:

- The CoC may be miscounting permanent supportive housing (PSH) beds and not including unused beds, in HMIS.
- There is some question whether System Performance Measures (SPMs) accurately reflect what is happening in the system, especially given that not all partners are using HMIS fully. Some of the inconsistences identified through the CoC Assessment include:

- SPM data shows that while the number of people returning to homelessness has gone down overall, the number of people returning to homelessness from permanent housing has risen between 2015 (5%) to 2021 (17%).
- SPM data indicates returns to homelessness has gone down between 2015 when it was 25% and 2021, where it was only 19%, but most of the stakeholder feedback indicates that many people are returning to homelessness from permanent housing placements.
- The total number of unduplicated individuals experiencing homelessness tracked through CE in HMIS from 2015 to 2021 rose and then steadily decreased - from 1,585 in 2015 up to 1,868 in 2017, then down to 990 in 2021.
- First-time homeless also follows a similar pattern. It went up between 2015 (1,125) and 2017 (1,361), but then steadily declined through to 2021 (726).

Use of data

Data collected through HMIS, PIT, and intake and assessment (HMIS + data from non-participating partners), is important to help tell the story of how the overall CoC is doing, but also how people move through the system, creating opportunities to identify gaps, needs, and disparities. While survey results indicated that over 80% of organizations say they are entering data into HMIS, it is unclear if that data is used for anything other than matching and referrals. Not only is it difficult for individual partners to pull data from HMIS, but we heard from stakeholders that there is not a great deal of trust in the data that is in HMIS.

> *"[Is there] use of data at the leadership level, YES. But anything deeper, NO! [There are] some program leaders who want to make data-informed decisions and trying to use their agencies' data."*
>
> — Interviewee

For HMIS to help tell a complete story and identify opportunities for improvement, HMIS data usage has to improve. The fact that the most active street outreach provider is prohibited from entering the data they collect about unsheltered individuals into HMIS is a significant hurdle. While many member organizations now have to have an HMIS point of contact, organizational staff are still not comfortable using HMIS on their own and often rely on the HMIS lead to pull their reports.

Additionally, Homebase heard from many CoC partners that the CoC is not doing "data-informed decision-making." While most stakeholders surveyed indicated that their organizations use data to better understand the people they work on behalf of and to better understand whether their organizations are meeting goals, the feedback from interviews and focus groups was not as positive. When asked whether the CoC uses data strategically, one interviewee shared, "Not all the time, no they don't. There used to be a workgroup from the CoC … we could talk about the data and then share it with the CoC. We would go back to the group and no one wanted to do anything with that information." Another interviewee spoke to whether data was used strategically, "At the leadership level, YES, but anything deeper, NO." The CoC needs to message that data sharing is important. It also needs to get people more comfortable dealing with data.

> *"But [there is] not time or investment to do their own data analysis. The City has been trying to do some analysis – but [they] are the only ones."*
>
> — Interviewee

Recommendations

Collectively, the CoC has strong leadership with data through the City of Winston-Salem. Through that leadership, there are a number of pro-active steps the CoC can take to improve HMIS participation and data fluency.

1. **Develop a data committee** comprised of 3-5 staff and organizations who can focus on data for the CoC.
2. Delegate responsibility to the data committee to **review the current HMIS system** to identify where it is working and where it can be improved to better support activities of the CoC.
    a. Review how CoC members are entering and/or using data from HMIS.
    b. Identify data fields that are empty or not useful to the CoC and HUD-required universal data elements that are not being used properly where training may be needed.
    c. Identify challenges in using the HMIS structure for entering data, pulling data, creating reports, etc and connect with other CoC-peers about their experiences.
    d. Make recommendations to the HMIS vendor and HMIS Lead about changes needed.
    e. Play role in reviewing draft data reports to ensure at least two separate set of eyes review the data and summaries before making public or submitting to HUD
3. Work with health care partner/s to understand the barriers that prevent participation of their outreach staff in HMIS.
    a. Review what is expected with HMIS participation.

   b. Determine what barriers exist and what may need to change to allow them to enter data into HMIS.
   c. Revise release of information (ROI) or agency safeguards to accommodate changes necessary for participation.
4. Train each CoC member organization's staff on how to enter HMIS data and how to use HMIS to evaluate and improve how they are working with clients.
5. Begin to integrate data analysis and evaluation into decision-making and strategic planning of the CoC.
   a. Identify staff and organizations who will undertake data analysis of HMIS data at least quarterly and produce a report for the Executive Team and the Operating Cabinet at least quarterly.
   b. Develop a set of key data questions that the CoC would like to use to monitor the performance of the CoC on a regular basis (e.g., system performance measures, racial equity facts, etc.).

Conclusion

The Winston-Salem / Forsyth County Continuum of Care is a vital community institution with an accomplished history of addressing homelessness in Forsyth County. However, many of the stakeholders in the homeless system of care see room for improvement. They feel disconnected from the CoC and, at times, unwelcome at its meetings. They are confused by its organizational structure and unclear on the roles and responsibilities throughout the system. They also see little action or change coming out of the CoC, and a reluctance to embrace new ideas or suggestions from a breadth of members. Some are frustrated by an HMIS system that requires a lot of data input, but that does not seem to be relied-upon for strategic decision-making within the CoC. Some worry that they may lose funding or otherwise suffer negative consequences if they air concerns or oppose ideas championed by certain lead agencies. To address these and other concerns discussed above, we have made recommendations for improvement in seven areas: (1) CoC structure, (2) leadership, (3) engagement, (4) coordinated entry, (5) shelter and housing (6) data and (7) services. A detailed Action Plan to help the CoC implement these recommendations will be submitted separately. It is our hope that, through these analyses, Winston-Salem and Forsyth County will see significant progress toward their goal of preventing and ending homelessness in the community.

Appendix A: Glossary of Terms

At risk of homelessness is a status given to individuals and their families who have unstable housing and inadequate income and resources.[10]

Behavioral health describes the connection between a person's behaviors and the health and well-being of the body and mind.[11]

Case management includes assessment, planning, facilitation, care coordination, evaluation and advocacy with people experiencing homelessness. Staff work with individuals and families to address their comprehensive needs to help them exit homelessness and stay housed.

Chronically Homeless is when a person has been homeless for at least a year, either 12 months consecutively or over the course of at least 4 separate occasions in the past 3 years. To be chronically homeless, the individual or head of household must also have a disability.

Continuum of Care (CoC) is the group organized to carry out the responsibilities prescribed in the CoC Program Interim Rule[12] for a defined geographic area. A CoC is composed of representatives of organizations including: nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless Veterans, and homeless and formerly homeless persons. Responsibilities of a CoC include operating the CoC, designating and operating an HMIS, planning for the CoC (including coordinating the implementation of a housing and service system within its geographic area that meets the needs of the individuals and families who experience homelessness there), and designing and implementing the process associated with applying for CoC Program funds.

> **CoC Program** is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by nonprofit providers, and state and local governments to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.

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[10] See 24 C.F.R. § 576.2 for complete definition of "at risk of homelessness" under the Emergency Solutions Grant Program.

[11] CDC, The Critical Need for a Population Health Approach: Addressing the Nation's Behavioral Health During the COVID-19 Pandemic and Beyond. Available at: https://www.cdc.gov/pcd/issues/2020/20_0261.htm

[12] CoC Interim Rule, https://www.hudexchange.info/resource/2033/hearth-coc-program-interim-rule/

CoC Program Interim Rule focuses on regulatory implementation of the CoC Program, including the CoC planning process. The CoC Program was created through the McKinney-Vento Homeless Assistance Act as amended by the HEARTH Act of 2009.[13]

Coordinated Assessment, Coordinated Entry (CE) or Coordinated Entry System (CES) provides a centralized approach to connect the region's most vulnerable homeless residents to housing through a single community-wide assessment tool and program matching system.

Coordinated Intake Center (CIC) is the Coordinated Entry system for the Winston-Salem / Forsyth County Continuum of Care operated by the United Way of Forsyth County.

Congregate Shelters are facilities with overnight sleeping accommodations, in shared quarters, the primary purpose of which is to provide temporary shelter for people experiencing homelessness.

Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.

Emergency Housing Voucher (EHV) is a program available through the American Rescue Plan Act (ARPA). Through EHV, HUD is providing 70,000 housing choice vouchers to local Public Housing Authorities (PHAs) in order to assist individuals and families who are homeless, at-risk of homelessness, fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking, or were recently homeless or have a high risk of housing instability.

Emergency Shelter is any facility with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for people experiencing homelessness in general or for specific populations. Shelter may include year-round emergency shelters, winter and warming shelters, navigation centers and transitional housing. These types of shelter have varying hours, lengths of stay, food service, and support services.

Emergency Solutions Grants (ESG) provides funds to assist people to quickly regain stability in permanent housing after experiencing a housing crisis and/or homelessness.

Federal Poverty Guidelines are issued each year by the federal Department of Health and Human Services. The guidelines are a simplification of the federal poverty thresholds and are used to determine financial eligibility for certain federal programs.

Homeless is defined by HUD in four categories:

[13] Id.

(1) individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided;
(2) individuals and families who will imminently lose their primary nighttime residence;
(3) unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and
(4) individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness.

Homeless system of care is another way of describing the Continuum of Care (CoC) and the network of partners who come together to work to support people experiencing homelessness or at risk of homelessness.

Housing and Urban Development (HUD), U.S. Department of, is the federal agency responsible for national policy and programs that address housing needs, improve and develop communities, and enforce fair housing laws.

Housing Choice Vouchers (HCVs), formerly known as the Section 8 program, are long-term rental subsidies funded by HUD and administered by Public Housing Authorities that can be used to help pay for rent.

Housing First is a well-accepted, national, evidenced-based best practice that eliminates barriers to housing, ensuring individuals and families can exit homelessness as quickly as possible. Housing First is an approach to quickly and successfully connect households experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered on a voluntary basis to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.[14]

Housing Inventory Count (HIC) is conducted annually to collect information about how many units of housing in the region are active and reserved for people experiencing homelessness. This includes emergency shelter, transitional housing, rapid rehousing, and permanent

[14] *What Housing First Really Means*, National Alliance to End Homelessness (NAEH).

supportive housing. To be included in the HIC count, the units must be reserved for people experiencing homelessness. In addition, to be included on the HIC, any Rapid Re-Housing units must have been actively in use by a particular client on the night of the count – subsidies that are available but are not currently being used to pay rental assistance on a particular apartment are not included in the count.

Low-barrier shelters are emergency shelters that have removed most requirements/obstacles for entry into the program so that households are more likely go indoors to connect to services rather than stay on the street. For example, unhoused residents are allowed to bring their pets and possessions, to live with their partners, and do not have to exit the shelter each morning. They are not expected to abstain from using alcohol or other drugs, so long as they do not engage in these activities in common areas of the shelter and are respectful of other residents and staff.

McKinney-Vento Act is a federal statute that has a more expansive definition of homelessness than the HUD definition. The Act requires schools to track students experiencing homelessness. For public education programs up through high school, homelessness includes people experiencing homelessness under the HUD definition, but also includes youth who are couch surfing or doubled-up (e.g., with multiple families sharing the same space).

Motivational Interviewing is a client-centered, evidence-based approach used by direct service providers working with people experiencing homelessness. It allows individuals to direct their own path toward the change they seek, rather than trying to convince them of what they need to do. The provider builds trust, listens, and then acts as a guide to help the client to identify their own personal next steps.

Non-congregate shelters provide overnight sleeping accommodations with individual quarters, such as hotels, motels, and dormitories.

People with lived experience is a term used to refer to people who have lived through the experience of homelessness and have first-hand knowledge of what it feels like to live unsheltered and/or to move through the homeless system of care.

Point-in-Time (PIT) count is a biennial process required of CoCs by HUD to count the number of people experiencing homelessness on a single night in January. The PIT count provides a snapshot of data available on the size and characteristics of the homeless population in a CoC over time.

Permanent Supportive Housing (PSH) provides long-term housing with intensive supportive services to persons with disabilities. These programs typically target people with extensive experiences of homelessness and multiple vulnerabilities and needs who would not be able to retain housing without significant support.

Prevention is a strategy intended to target people who are at imminent risk of homelessness (whereas diversion usually targets people as they are initially trying to gain entry into shelter).

Rapid Rehousing (RRH) provides rental housing subsidies and tailored supportive services for up to 24-months, with the goal of helping people to transition during that time period to more permanent housing.

Shared housing is a living arrangement between two unrelated people who choose to live together to take advantage of the mutual benefits it offers. Families, students, young adults, seniors, and Veterans have been using this arrangement for generations. It is now recognized as a viable option for people exiting homelessness.

Street outreach involves multi-disciplinary teams who work on the streets or in encampments to engage with people experiencing homelessness who may be disconnected or alienated from services and supports that are offered at an agency.

Supportive services include assistance applying for benefits, mental health and substance use services, outpatient health services, information and referral services, child care, education, life skills training, employment assistance and job training, housing search and counseling services, legal services, outreach services, transportation, food assistance, risk assessment and safety planning (particularly for individuals and families experiencing domestic violence), and case management services such as counseling, finding and coordinating services, and monitoring and evaluating progress in a program.

Transitional Housing (TH) provides temporary housing accommodations and supportive services. While many households benefit most from direct connections to permanent housing programs such as RRH or PSH (which are often more cost-effective over the long term), transitional housing can also be an effective support in the intermediary. In particular, certain subpopulations, such as people fleeing domestic violence and transitional age youth, can meaningfully benefit from a transitional housing environment.

Trauma-informed care is a practice that focuses on understanding and compassion, especially in response to trauma. The practice utilizes tools that empower people to work toward stability. It recognizes a wide range of trauma that can impact people experiencing homelessness; physical, psychological, social, and emotional trauma. It emphasizes the safety of both clients and providers.

U.S. Census Bureau conducts a demographic survey that measures income, poverty, education, health insurance coverage, housing quality, crime victimization, computer usage, and many other subjects. The U.S. Census data helps to understand the overall composition and conditions in each community.