P1. NY-603 has effectively leveraged access to more permanent housing through the ongoing scale up of permanent supportive housing through state-funded initiatives, PHA coordination and the use of voucher programs, increased and enhanced rental assistance programs, coordination with developers, and landlord engagement.

Our CoC has been able to significantly expand permanent supportive housing through state funded initiative to increase permanent supportive housing (Empire State Supported Housing Initiative [ESSHI]), the Medicaid Redesign Team (MRT) and Homeless Housing Assistance Program (HHAP). ESSHI beds require participation in Coordinated Entry (CE) and strongly encourage the use of Housing First, and other partners with different funding sources have also been willing to participate in CE. [see HHAP annual report and CE MOU] Our CoC has also dramatically increased the use of vouchers for persons experiencing homelessness through EHV, HCV, FYI, and has partnered with the largest PHA in our region (NYS HCR) to apply for Stability Vouchers. Our CoC has connected more households to EHVs than any other CoC in NYS and has one of the highest lease-up rates. HCV set aside vouchers have allowed access to sustainable permanent housing options for those with the greatest barriers and those that are interested in moving on from PSH to add capacity for other high barrier chronic households. [see NYS HCR EHV tracking portal report]

Capacity for rental assistance programs has increased each year. RRH has been proven effective within our CoC for many years, starting with SSVF RRH playing a significant role USICH's certification that we had effectively ended Veteran homelessness in 2016. [See USICH Letter] Since then, RRH has been used to address family homelessness, domestic violence, and youth homelessness, bringing down overall homeless numbers. Since COVID-19 our CoC has started to use more RRH resources to serve high barrier single adults, including people living unsheltered, and has had success achieving housing stability through leveraging more intensive support services and bridging households to more long-term and supportive housing options such as PSH or vouchers. We also partnered with our two local DSS offices to propose an enhanced rental supplemental program (RSP), which will be targeted to serve unsheltered populations in single room occupancy (SRO) or private units to better align with the local needs and preferences of those on the street.

Our CoC partners with local community development offices and affordable housing developers to identify opportunities for new housing that is accessible and affordable to those experiencing homelessness. Long Island's history of strict laws and zoning that restricted home ownership to non-whites perpetuates geographic segregation, housing discrimination and resistance to almost all affordable development. The CoC partners with local advocacy groups that urge for the development of more affordable housing and seek to combat a significant "Not In My Backyard" sentiment (NIMBYism).

P1-A. N/A

P1-B. N/A

P1-C1. As part of ongoing local scale up of rental assistance programs and access to vouchers, sparked by local partners with PHAs and EHV, the CE team added a full-time PHA Coordinator. Both CE and domestic violence CE (DV CE) teams each added a full-time Landlord Engagement (LLE) Specialist to enhance capacity to coordinate referrals, housing search, and placements and to build off the success of PHA relationships and advocating for more homeless preferences and set asides. The CoC uses a shared/partnered approach to landlord engagement through the development and maintenance of shared landlord/rental lists, regular LLE meetings, CoC case conferencing, and joint landlord recruitment efforts with partners such as VA/VASH, PHAs, DSS, and local housing programs. Our CoC leveraged partnership with the Long Island Board of Realtors (LIBOR) to engage with landlords through advertisements, marketing letters, group presentations, magnet events, networking, and one-on-one recruitment meetings. With a wide array of rental assistance options, we explained what different programs offer, in terms of subsidy coverage amounts, support services, mediation support in place, incentives and other benefits to find the best and most comfortable match for each landlord. Overwhelmingly, financial incentives such as sign on bonuses and rent guarantees were the most effective negotiating tools, along with identifying a direct contact for landlords to call if there was an issue. The CoC has dedicated pages on the CoC website for housing search resources and for landlords and leverages established social media pages that are active for landlords posting opportunities as well as for those seeking units to ask for help with their search. The CoC offers LLE trainings to individuals experiencing homelessness as well as partners such as shelter providers and other case managers/advocates and has developed a housing search and tenant preparedness handbook that is distributed and available on the CoC website. Our CoC also partnered with NYS HCR to develop a post-move case management program for households placed through EHV to ensure streamlined move-ins, easier transitions into housing and more support for sustainable

housing outcomes. The CoC has worked with various PH partners on developing landlord MOUs and other agreements that clearly outline the agreed upon roles and expectations of each party.

P1-C2. Due conditions resulting from the COVID-19 pandemic, CoC partners had to work harder to identify units, negotiate with landlords, find ways to compete financially, and counter the frustrations of landlords that went unpaid for long periods of time and in some cases, keep landlords renting as opposed to selling off homes when they were experiencing loses/increased landlord-tenant tensions. The CoC worked directly with local court systems seeking to salvage relationships with frustrated landlords by offering incentives, new prospective tenants on demand, and rent-guaranteed options. The CoC also advocated for Accessory Dwelling Apartments (ADU) to allow for more local housing capacity on a statewide level and was as successful in furthering ADU flexibilities within the Town of Huntington. The CoC works with local advocacy groups such as YIMBY and Huntington Housing Coalition to further development and landlord relationships.

Our CoC has been an active member of the Built For Zero network since pre-COVID, focused on addressing chronic homelessness, which often overlaps with unsheltered homelessness in our region. Within the past year, we have started working with BFZ as part of the Property Engagement cohort, engaging in outcomes tracking and action items around enhancing landlord engagement and homeless exits as a result. Our CoC has created a BFZ property engagement working group that continues to develop new ideas and strategies to make landlord engagement as effective as possible. Specifically, our the BFZ working group is developing training material such as an updated LLE guidance manual, developing best practices/lessons learned as written guidance, and LICH is in the process of submitting requests for funds for an additional landlord engagement staff as part of the CE Helpline/Diversion team, a full-time staff to conduct trainings and recruit landlords, and for flexible landlord funds to incentivize landlords and remove barriers for people moving into housing.

P1-C3. Outcomes are measured to determine the success of LLE strategy using tracking of the EHV portal, HMIS homeless exits, CE events, RRH/PSH project intake and move-in dates, BFZ data, HUD System Performance Measure 2 (homeless exits), and HIC reports (PH beds/units). The expansion of shared landlord listing and continuity of relationships with currently engaged landlords are important measures of strategy success and are expected to be reflected by decreasing the average number of days until move-ins to units with vouchers and RRH programs.

P2 - N/A to NY-603 CoC

P3-A1. Our CoC covers areas where people are not easily seen by the public due to inclusion of include rural lands and vast woodlands in CoC geography, weather that changes drastically from summer to winter, and because people are living in the woods in tents, are highly transient and living in vehicles, or otherwise seeks to remain unseen. This population, in some cases, became even more isolated during COVID-19 due to many supportive services closing their doors temporarily. To provide full coverage, equitable access to resources and supports, and coordinated efforts, our CoC must heavily focus on ensuring that we can locate and identify every person living unsheltered.

Our CoC/CE team has managed a Street By-Name List since 2019. This list pulls data and intel from many sources and partners such as HMIS (street outreach), local homeless drop-in centers, food panties, faith-based partners, libraries, Street Outreach Committee case conferencing, localized taskforces, dedicated street outreach hotline calls and other community referrals. Our CoC also partners closely with local police to de-criminalize homelessness, more supportively and effectively engage on the street, and identify anyone living outside. As of 2021, county police developed a Behavioral Health Unit (BHU) and used their own data/resources to create precinct-level By-Name Lists of anyone that interacted with, was observed by, or reported to local police. Additional data is shared on those living on the or discharged to the street through health systems such as “PSYCKES” and “Healthix,” as well as other local institutions such as jails, re-entry programs, and rehabs. Through frequent engagements with people on the street and PLE involvement, those closest to street homelessness are often those that are our best resource for identifying people on the street, where they are likely to be, and how to best engage and support that population. Within our CoC, in the last year, Street BNLs have identified/tracked more than 400 unique households living unsheltered. On Long Island, significantly less than 1% of households presenting on the street are families with children, and in those rare occurrences, households are quickly placed in shelter or diverted. Our local strategies are based on the presenting street homeless population, which is overwhelmingly single adults and multi-adult households, most often between the ages of 45-67. About half of those that present on the street experience chronic homelessness, and an increasing number are non-US citizens and not eligible for any year-round shelter, per NYS OTDA/DSS.

Commented [AL1]: What are some examples of these?

Commented [MG2R1]: Providing LL fact sheets with benefits of programs, removing transportation and/or childcare barriers to be able to view units, identifying a point of contact for LLs to call when needed, connecting to LL financial incentives whenever possible

Commented [MG3R1]: LL also receive Housing First scores to ensure best landlord/client matching possible.

Commented [AL4]: This answer can be strengthened with more information on how we use data to determine whether LLE strategies are working.

Commented [MG5R4]: Tracking # of housing applications before acceptance (current average = 8), average housing search time, LOT reductions. Comparing households lease up time and success for those that have direct housing search assistance v not. Tracking return landlord partners (re-rent to homeless households in coordination with CE/CoC).

Commented [AL6]: I think we should speak to our plan to coordinate LICH street outreach with future street outreach teams to reach as many people as possible while not duplicating efforts.

Commented [MG7R6]: All SNOFO SSO must be CE access points, regularly trained, participate on SOC and unsheltered PIT. Will participate in BNL tracking and street case conferencing. Will track coverage rates/areas to ensure collective coverage and decrease duplicative efforts.

Outreach is targeted, based on partner and community referrals, general canvassing, and always before severe weather. The CoC tracks canvassing efforts by location, as well as successful enrollment rates into street outreach programs based on geography and demographics to strive for equity in outreach and outcomes. This includes partnered outreach based on individual needs. Street Outreach Committee meetings and case conferencing ensure that all known households on the street are being reached and resources are used efficiently by avoiding duplication of efforts.

P3-A2. Outreach is currently conducted five days a week, mostly during business hours, with some outreach efforts scheduled for the early mornings and evenings as possible. General canvassing increases each winter and before any major inclement weather conditions. With the increase in population presenting on the street more than double since before COVID-19, engagements with each person on the street have become less frequent. Coverage gaps can be achieved with the addition of proposed SNOFO street outreach applicants. Outreach gaps include frequency of outreach and engagements, and 24/7 hotline/outreach response available in the middle of the night and early morning when necessary.

P3-A3. All local street outreach teams are encouraged to be housing-focused, culturally competent, and highly mobile, to supportively meet people where they are at and determine specific actionable steps towards temporary and permanent housing placements. The CoC's Coordinated Entry Team has a direct arm of street outreach workers that uses a peer model with involvement from persons with lived experience. Using a phased approach to first ensure safety, reduce harm, and meet essential needs, the team then focuses on removing barriers towards housing and develop a client-driven housing plan with support. Street outreach teams also seek to establish rapport using introductions and warm handoffs from locally trusted individuals and groups within each community. To reach all persons living in wooded areas, our CoC has developed specific encampment response teams that include Veterans, non-uniformed police, peers, and crisis response. Street outreach teams also leverage technology to find encampment areas by using satellite imagery to find arial views of clearings in wooded areas and active encampment sites. Although local DSS shelter continues to be accessed less/more people remain on the street, street outreach teams ensure that whenever shelter is desired that direct transportation is provided, peer advocates will accompany households to DSS/shelter, faith-based low barrier shelters are utilized whenever available, and warm handoffs and case conferencing is used to ensure transition of support to shelter staff.

Permanent housing-focused approaches are client-driven, leverage resources, are highly mobile, remove transportation barriers, include benefits enrollment, allow for streamlined street to permanent placements with no requirement to first enter shelter. Over 80% of placements to PH are directly from street and households never enter shelter. All CoC, ESG, and ESSHI permanent housing use housing first approaches. The CoC partners with temporary faith-based winter shelter initiatives to place households in PH before winter shelter end dates such that households do not return to the street. In some ways street outreach teams, even using locally proven approaches, are only as strong as the resources behind them. The CoC continues to seek to develop more PH that adopts housing first approaches, advocates to loosen or expand eligibility restrictions based on either funding source or program discretion and works to create low barrier shelter alternatives.

P3-A4. Our CoC uses a targeted universalism approach, where to achieve the goal of ending homelessness within the CoC's geographic area, focus is placed on making sure highly vulnerable groups with high barriers to exiting homelessness are prioritized resources and outreach. The CoC has identified people in racially marginalized communities (BIPOC, Hispanic, Native Americans), people without US citizenship, those that have been negatively impacted by other inequitable systems, LGBT people, and youth as highly vulnerable households. Addressing local unsheltered homelessness requires more nuanced and/or different approaches based on the area that people are on the street. In some areas, strategies must account for deeply rooted histories of over policing, arrest rates on predominantly BIPOC individuals, and overall distrust of enforcement authorities, government, and outside entities not from within an area. Focus on staff alignment with the population served and PLE involvement, utilizing non-traditional and/or localized resources, and outreached potential SNOFO applicants that were deeply engrained in local support networks of communities that are marginalized are all part of the CoC's strategy to make engagement efforts with these communities more successful. Street medicine initiatives are targeted to marginalized areas that are most likely have less access to health care and/or be undiagnosed and untreated for disabilities and other illnesses. Coordination with local institutional settings is particularly important when supporting those that experience chronic homelessness on the street. Specific attention is given to areas that are under canvassed such as Town of Islip and East End of Suffolk County, and those who are highly vulnerable hardest to serve including people without a successful engagement/HMIS

enrollment, those without phones, those hardest to physically access (ie deep into wooded areas, living in vehicles or using rail lines and frequently changing locations), those that have been sanctioned from DSS shelter, those that returned to homelessness, and those where encampment sweeps had occurred or have otherwise been displaced/criminalized.

P3-A5. Connections to permanent housing are best ensured by using person-centered approaches, honoring client preferences whenever possible, providing transportation and accompanying on intakes, housing trial stays, roommate meet and greets, review of lease/program rules and client rights, and providing post-move case management. Case conferencing ensures that all efforts are being made to meet participant needs. While street outreach teams are encouraged to use best practices described above, there is a specific unmet need for greater street outreach capacity that is housing focused, is targeted to serve marginalized communities, and is directly partnered with Coordinated Entry for streamlined access to housing and services. All street outreach applicants through SNOFO must directly address these gaps.

P3-A6. CE Street Outreach teams include PLEs and outreach to networks of PLEs takes place on a regular basis to recruit more workers. Job descriptions removed criminal history and secondary education requirements and placed greater emphasis on lived expertise. All SNOFO applicants were required to specifically document how PLEs would be involved in program design, development, staffing, and training. Available training for street outreach partners includes assertive engagement, critical time intervention, trauma-informed care, implicit bias, cultural competency, engagement training from PLEs. The CoC is working on guidance in partnership with our TA provider to assist CoC partners in better involving PLE in the processes.

P3-B1. The CoC's overall strategy to address unsheltered homelessness has three major components: 1) Advocate for changes in emergency shelter operating procedures to move more people inside while meeting their needs and preferences, 2) Expand capacity for low barrier shelter the connects participants to permanent housing, and 3) Increase the number of available permanent housing programs and beds through CoC partner recruitment and advocacy for more housing vouchers.

Although our CoC is in a right to shelter state, NYS shelter regulations related to eligibility and requirements pose major challenges. Since COVID-19, rates of street homelessness have increased significantly, where as many as 1 in 3 single adults experiencing homelessness in Suffolk County were on the street and not in shelter. DSS has closed almost 30 shelters in the past few years due to decreases in shelter rosters, but there has been a continued to trend where single adults increasingly present on the street and do not enter DSS shelters. The following conditions have contributed to high rates of unsheltered homelessness in our region: 1) Required shelter payments of between 50-90% of a household's income create resistance to going into shelter and can lead to households leaving shelter back to the street. This is also one of the most significant contributors to increase average length of time homeless as households in shelter are not able to afford to leave with the little income they can retain. The CoC advocates for decreasing or eliminating shelter payments to DSS and OTDA. 2) Many individuals felt as though their reasonable accommodations were not being met by DSS, often resulting in people living on the street. Due to inequities in other systems such as access to medical services, it is more likely that individuals that are part of the BIPOC community are undiagnosed and unable to provide documentation for a reasonable accommodation in the first place. A very common scenario that was reported was an individual stating that they need/want a private shelter setting (non-congregate) but were offered congregate placements and as a result, did not enter shelter and remained on the street. 3) Households must physically present at a DSS community center to apply and access shelter through DSS (3 centers in one county, 1 in the other), presenting major challenges for households without access to transportation. Locally, our street outreach teams can provide direct transportation to DSS and accompany individuals to ensure they are successful in applying for shelter and other benefits available through DSS, but this capacity is limited. 4) Income/Asset Guidelines make households deplete any small amount of money they have by paying for a motel room themselves before they can re-apply and be placed in shelter. Depleting all resources also makes it much harder for households to exit homelessness if they do become homeless. Locally, our CoC enhanced CE helpline/diversion team to connect with people earlier, specifically before or while they were temporarily paying for a motel to see if we could problem solve before they go to the streets or need shelter. DSS additionally funded a homeless prevention/front door program that would seek to divert households. 5) Households that are non-US citizens are not eligible for shelter through DSS. This makes up for than 50% of the population presenting on the street in some areas within the CoCs jurisdiction, including two towns that have amongst the highest rates of street homelessness. To address this need, the CoC enhanced partnership with faith-based partners, winter bed

programs, leveraged legal advocacy, used EFSP dollars for rental assistance, and coordinated directly with workforce housing. 6) Multi-adult households are often unwilling to access shelter through DSS and be placed in separate shelters. While there is a small amount of shelter settings that can accommodate adult couples, it does not nearly meet the number that are presenting on the street. Locally, CE allowed households to self-identify and studio and 1-bedroom PSH units were used to match adult couples to, as well as RRH, which would allow for a specific unit that could meet their needs. The CoC has also presented on the need for low barrier shelters during every legislative meeting for the last two years, including highlighting local examples of where low barrier shelters are successful and available funding. Part of the work of the PLE Advisory Board will be to elevate voices of those impacted directly but the lack of immediate shelter options. The CoCs overall strategy is to seek to change the DSS shelter system to one that works better for people, while simultaneously seeking to develop alternative shelter options.

The CoC advocates strongly for low barrier shelters and permanent housing that uses a Housing First approach. Our CoC demonstrated success with low barrier shelter when low barrier shelter was enhanced low barrier shelter capacity as part of work to end Veteran homelessness. VA GPD Low Demand beds continue to be successful in getting people inside, including those that are most vulnerable. Faith-based winter shelter programs have been the most successful at getting people inside quickly, as was the INN Journey program (shelter program funded through ESG) which served mostly single adults that were not US citizens, a population that has increased substantially since COVID-19 and accounts for a large part of the overall street homeless increases locally. The CoC is seeking funds for multiple TH-RRH projects through this application, and this potentially could provide a significant scale up of resources to effectively get people off the street quickly. Street outreach teams have shown effectiveness with placing people directly from the street into permanent housing, but not at a rate that could get everyone inside with current capacity. Applicants for SSO projects under the SNOFO will help close that gap. The CoC continuously advocates for expansion of PSH, which has been demonstrated to be a program model that well serves the needs of people living unsheltered and can move them directly inside. Active recruitment for new projects and expansions takes place annually as preparation for the funding round. For the SNOFO, significant resources were dedicated to providing education and technical assistance for new applicants and as a result the CoC was able to recommend two applicants for PSH funding.

P3-B2. The CoC has had isolated success with low barrier shelter models both due to the DSS monopoly on shelter operations, but also the lack of nonprofits willing to operate such a model. Most faith-based partners will not accept government funding that drastically restricts how they can operate. For others, concerns arise about operating a program that requires significantly more support with significantly less money. Other local groups have instead gone the route of acting as a landlord and operating boarding homes, which are undesirable for people coming off the street because the houses are unregulated and often have more people living in each room than a congregate DSS shelter. The CoC has funded three TH-RRH models within the CoC (2 DV, 1 Youth) which has provided immediate access to crisis beds then permanent housing for vulnerable populations. The VA has also shown continued success with their beds. Dramatically changing a shelter system that is well established and enforced on a state and local level, with no direct oversight from the CoC will take time and seeks to access every way to address the problem.

P3-B3. A key lesson learned in the past years has been that with low barrier shelters, particularly motel placements, have been more effective at getting people into shelter than getting them out. The lack of housing focused case management and strong housing search assistance that can locate private units similar or better than a motel setting are significant contributors. Since COVID-19, there have been some programs and efforts to separate people and use motel settings. However, without adequate support services in place and housing-focused case people that reside in motels experience homelessness two to three times longer than those in shelter, and in some cases, longer than those living on the street (Nassau County). Permanent housing placement rates directly from the street are higher than placement rates from motel programs. One of the major factors to why people remain in motels is because there are few permanent housing options that offer private settings, have no stairs, are conveniently placed in communities with walkable access to resources and/or easy access to public transportation. TH-RRH projects proposed through SNOFO must demonstrate a model with significant funding, resources, and emphasis on how households will obtain and maintain permanent housing. The CoC is now specifically working with developers, HOME-ARP PJs and other local funders and housing partners to develop SRO housing, as this seems to be biggest factor that is keeping people living outside or in motels, if offered a motel placement as a rarer occurrence. CoC PSH applicants are also being strongly encouraged to apply for PSH that has studios and 1-bedrooms. The CoC continues to look for new partners and existing partners that are willing

Commented [MG8]: We may want to also talk about roommate matching initiatives, as not as households will be able to live in private units.

to consider using ESG and other funds that are readily available to create more low barrier shelter. Roommate matching is an encouraged practice within the CoC for households that cannot sustain private units on their own.

The expansion of voucher access to homeless households with the EHV program in the last couple of years has provided further evidence that providing a permanent housing subsidy that allows participants to choose their own units is a highly effective way to help people exit homelessness and keep them stably housed. Implementation of the EHV program has demonstrated that housing search assistance is a necessary and highly desirable service. Case management approaches overall, have sometimes focused more on meeting immediate needs as opposed to creating plans and access to permanent housing. The CoC has added landlord engagement staff to both CE and DV CE to continue building a network of landlords that can be partnered with to homeless households with RRH or vouchers. As part of the Built for Zero Property Engagement cohort, CE staff are actively learning new methods for landlord engagement and developing capacity.

P3-C1a. Our CoC has seen firsthand how shifts to housing first approaches have allowed housing and service opportunities to those with the greatest barriers and strongly encourage the use of housing first whenever possible. Many households that continue to be referred through Coordinated Entry have been denied access to housing/services in the past and are now consistently able to successfully access housing quickly, aligned with their preferences and needs. All CoC and ESG-funded permanent housing programs and CE projects in our region operate as Housing First. All applicants for this SNOFO, regardless of project type, must adopt a housing first approach. The CoC formalizes this as a threshold to apply, and applicants must sign a CE MOU that includes the requirement to operate using a HF model. All SNOFO applicants are also required to be trained on CE and HF regularly. The ongoing use of effective and appropriate housing first is ensured through client experience and outcomes such as having CE staff present for housing intakes and tracking successful enrollments, as well as through CoC monitoring including a review of support services offered and case reviews, a formal review of all discharges from programs, and through formal review of all program documents. The CoC actively promotes the use of HF with all housing program funders and partners and has effectively influenced other funders to require HF. The greatest barriers with housing first were with permanent housing programs funded through the Office of Mental Health. Our CoC provided verbal and written testimony, including case studies and local CE outcomes data that found racial disparities in those approved for mental health housing and services. Dually funded CoC and OMH beds require housing first and have shifted some practices with the OMH referral system to reduce some barriers to access.

P3-C1b. The most impactful partners that provide housing capacity that exits more people out of homelessness are those partners and programs that have little or no barriers to permanent housing access. This includes significant permanent supportive housing scale up through state funding (ESSHI/HHAP/MRT), as well as coordination with PHAs to reduce restrictions for households applying for EHV. When CE was first implemented locally, only CoC/ESG-funded PH were effective referral sources. Currently, more than 65% of PH referrals were to non-CoC/ESG-funded beds (including EHV). Coordinated Entry has directly referred over 820 unique households to permanent housing in the last year and has leveraged more EHV resources through NYS HCR than any other CoC in the state. Additional PHA partnerships have led to homeless set aside units, modifications to preferences, development of post-move case management programs, and leveraged vouchers to pair with tentative HOME-ARP projects.

P3-C2. Getting those hardest to serve linked to housing and services requires housing-focused case management, targeted to people and areas that are least likely to be connected to resources. The CE street outreach team maintain lower caseloads in order to adequately and regularly provide outreach and support. Engagements are further intensified during times of initial engagement and during the time of transition into temporary or permanent housing. Coordinated Entry uses person-centered approaches and clients determine the types of housing and services that they are willing to accept. Locally, when clients are offered housing and services that align with their preferences, acceptance rates increase by over 40%. The use of dynamic prioritization further ensures that households are connected with the resources that best meet their needs. On average, it currently takes slightly over nine months to place a household directly into permanent housing from the street. Increases to low barrier PH and housing-focused street outreach would decrease the average length of time on the street before placement with more low barrier bed capacity and more staff to work more frequently and intensively with households living unsheltered. With a current team of 6 FT street outreach staff as a direct arm of CE, based available low barrier permanent housing that meet the needs and preferences of people living unsheltered, places an average of 45 households directly from the street into permanent housing each year. With the addition of state-funded permanent supportive housing expansion (ESSHI), the CE Street Outreach team

was able to place an additional 25 individuals directly from the street into PH, including some that had service needs beyond what was able to be provided or leveraged by other CoC PSH. SNOFO applicants would project to more than double the number of households exiting the street to permanent housing, through PSH, TH-RRH, and additional housing-focused street outreach.

All CoC PSH is chronic dedicated and the local CoC prioritizes those with the greatest length of time homeless, those living unsheltered or otherwise the greatest barriers and vulnerabilities. Most CoC PSH beds are filled by persons coming directly from the street into permanent housing. CoC performance when serving those with the greatest barriers varies to some degree by project, based on unit configurations (congregate v. private units), staff structures/alignment with populations served, and support services offered. For example, PSH projects serving chronically homeless single adults that operates as shared housing, including shared bedrooms, although Housing First, are harder to successfully refer clients based on housing needs and preferences, and have lower retention rates. The CoC continues to encourage PSH modifications and applications that align with the need and preferences of those within the local homeless system. As one of the most common factors of those that experience homelessness longest is only being willing to live alone and not in any shared housing, all PSH and other PH development is encouraged to explore SROs/private units whenever possible. SNOFO applicants have been provided direct feedback from person's living or previously unsheltered about the barriers they have faced in the past when seeking to access programs, from lack of ID and documentation, challenges with sobriety, lack of access to healthcare, transportation issues, and being judged unfavorably based on appearance and/or behaviors. SNOFO applicants consider these factors into program design and are aware of the types of supports necessary to get people inside and keep people housed.

P3-C3. provide the evidence that supports the use of the CoCs current strategy; and

Prior to the CoC's adoption of Housing First, Coordinated Entry, local prioritization policies and an expansion of housing-focused case management, less than 8 households per year were placed into CoC PH either directly from the street or with a history of being unsheltered. Our CoC has demonstrated that applying housing-focused street outreach and lessening barriers to accessing housing has directly resulted in significantly more PH placements of persons living unsheltered.

Prior to the housing-focused street outreach team that was developed alongside CE, the only street outreach available within our CoC's jurisdiction was solely focused on distribution of essential items, was shelter-focused as part of a local DSS effort to ensure everyone on the street was aware of shelter options, and/or was funded to exclusively serve restrictive subpopulations that made up very small percentages of those presenting on the street and within the homeless system overall (ie Veterans, HIV, diagnosed mental health).

CE team added more vehicles to remove barriers related to transportation to shelter/housing/medical/other. Local CE PH referral data demonstrated that when CE staff transported and accompanied households to permanent housing intakes that households were more likely to accept PH opportunities and less likely to have attempts from the provider to be screened out/rejected. The rate of successful enrollments into PH for people living on the street went from less than 20% to greater than 80%.

CE teams also strengthened training and tools related to identifying housing preference and needs and coordinated with PH providers to share pictures/videos of specific units that were available to help individuals consider opportunities, and provided trail stays and roommate meet and greets for households that were ambivalent about accepting housing placements.

More than 90% of households presenting on the street and being engaged by CE state that they are interested in permanent housing placements but not existing shelter resources. In almost all cases, our CE team is working with people on the street who are aware of shelter options but are only willing to explore PH opportunities due to the current regulations/requirements associated with shelter placements through DSS. Of the two large counties within the CoC's jurisdiction, the county that does offer motel/non-congregate shelter placements for those with reasonable accommodations and/or as shelter overflow, has less than 50% total persons presenting on the street at any given time. Most people in the county that offers motels that do reside unsheltered are ineligible for shelter based on citizenship status.

INN Journey Program was created during COVID, funded as a low barrier shelter for those not eligible for DSS shelter. The shelter program served 60 households and was at/overcapacity, almost immediately, referred by CE. This project served as a large-scale pilot of how low barrier shelter access could decrease street homelessness, offer immediate shelter options that better aligned with persons needs/preferences, and better connect households to housing and services supports when no longer in survival mode, living outside.

P3-C4. identify new practices the CoC has implemented across its geographic area in the past three years and the lessons learned from implementing those practices.

The most important lesson learned was to acknowledge the overwhelming challenge of covering a large area with vast woodlands, unique circumstances of each community because of segregation/inequities and variations in available resources and levels of trust, and the need to shift from outreach that was focused on helping people survive with distribution of essential items and offering shelter, to housing-focused intensive street outreach efforts to address the significant barriers in place for persons unsheltered. At the core of needed changes was importance of community relationships and leveraging new partners and determining best practices during a pandemic and significant increases to the number of persons presenting on the street. In terms of shelter bed capacity, we learned that having enough shelter beds was not enough to make street homelessness rare, brief, and non-recurring because all shelters locally were subject to state and county level eligibility restrictions, which created significant barriers to access and shelter placements were not offered in a way that met all person's needs. We also continued to learn the importance of elevating the voices of those experiencing homelessness as people were not able to access shelter when needed, more people were on the street, and local politicians had the potential to respond to local constituent pressure in short-sighted and inhumane ways, such as through enforcement/criminalization and encampment sweeps.

ESG-CV was used to rapidly scale up street outreach. Street outreach that was housing-focused and could [temporarily] expand beyond only prioritizing those experiencing chronic homelessness on the street to engage more households and enhance coordinated efforts, diversion work, and vaccine outreach and other COVID-19 response. Further, during COVID-19, local CoC prioritization changed to first refer those with the greatest risks of COVID-19 and those living on the street or in congregate shelter for all existing PH, and more RRH capacity was used as bridge housing to get people off the street and out of shelter as quickly as possible. The CoC also was directly involved in county re-imagining policing efforts, which included the development and direct partnership with a new behavioral health unit within local police departments. Other partnerships included FQHCs which initiated street medicine components of outreach in both counties within the CoC.

We also learned that effective adoption of HF requires leadership buy-in, but also requires more training/support and PH support services. Some PSH providers struggled significantly to provide adequate support for a higher acuity population and had to find funds elsewhere when shifting from a population that had income to a population that often does not. Retention rates within PSH projects that were not robustly funded for support services and/or used shared housing models decreased. Congregate units (shelter and permanent housing) are not desirable, and the majority of people will remain on the street if that is all we have to offer. The challenge is often that identifying units within FMR price points and operating sustainable projects requires shared living. In the last two years, all non-congregate PH referrals have been filled immediately, with often long waiting lists, whereas shared PH units that become available face delays in referrals. Specifically, a PH unit that is shared can take between 12-20 households being offered the opportunity before someone accepts. This also includes delays from people that are willing to do trial stays and then decide not to accept and often leave within 24 hours. The CoC worked with other funders to help leverage funding to enhance PSH service provisions and to encourage housing first practices for PH projects funded through other initiatives-state, county, and local. Housing First, however, continues to be a challenge and we face resistance from some local agencies, which has resulted in agencies voluntarily giving back CoC funds and/or resisting housing first principles and debating its efficacy. The CoC works to provide as much support and training as possible, involves PLE in feedback for best practices, and offers local data on outcomes that refutes any perceptions of ineffectiveness.

The CoC formally established a PLE Advisory Group which allowed for more specific insight into barriers faced, how to streamline access to resources, and the types of support services and how they are offered to be most effective/utilized. This has already resulted in a new CE Assessment tool, developed in direct consultation with PLEs and then piloted by diverse groups of persons experiencing homelessness.

Intention of honoring preferences v. reality of where units exist (mostly driven by rental market). Households coming from middle-upper class neighborhoods significantly less likely to be able to access housing in that area to return to community based on housing market compared for FMR/rent reasonableness rates. The CoC enhanced landlord engagement strategies and worked locally to identify flexible funding that could be used for landlord incentives and/or to remove barriers to entering housing such as utility arrears, the need for furniture and supplies, moving assistance, and covering application fees and deposits. For single adults, our CoC continues to work to develop PH that includes SROs and private units and has enhanced roommate matching capabilities through surveys, group meet and greets, and adding specific discussions to housing preference meetings about who someone would be willing to live with.

Our outreach strategy for SNOFO applicants needed to seek to address all local goals and acknowledge local challenges/shortcoming. We found that there were already local groups meeting local community needs and with established trust but not through permanent housing operation. Barriers to applying for funds was significant for first time applicants that did not have robust development staff and familiar with HUD/federal grants. SNOFO required significant outreach and education on priorities, funding process, etc. without advance knowledge of SNOFO. CoC Planning staff needed to offer regular office hours, including frequent one on one technical assistance meetings on nights and weekends to address significant learning curves with esnaps and the CoC process.

P4-1a. Current and planned housing-focused street outreach uses measurable outcomes such as number of permanent housing placements, housing applications completed, connections to medical, benefits, employment, and other resources to directly help clients exit homelessness and determine success of engagements. CE events including number of engagement attempts, length of time before successful enrollment in street outreach, average length of time from initial engagement to intake and/or assessment, time from initial engagement to permanent housing referral, and destination following discharge from street outreach programs are all tracked to optimize street outreach strategy in real time and determine the need for additional partnerships to strengthen efforts. Existing leveraged partnerships for supportive services are evaluated by the number of successful referrals to partner entities. Community response street outreach, which focuses on broad canvassing of communities and responding to calls on the CE helpline, have measurable outcomes that include number engagements, number of people identified as street homeless, effective assessment of chronic homeless status, and connections to other community supports.

In our CoC, data from current street outreach efforts, intakes, and outcomes display an increased need for: greater access to psychiatric evaluations to process referrals to permanent housing resources (SPA), the capacity to cover racially marginalized communities, focused partnerships with immigrant advocacy organizations/organizations who provide supportive services in Spanish, highly mobile street outreach, and transportation services which was a highly prioritized ranking criteria during the local competition. In response, the CoC recruited applicants under the SNOFO who have ties to under-canvassed communities and have the capacity to provide a range of supportive services, including streamlined access to mental health care. SNOFO applicants for Street Outreach were required to use a housing-focused street outreach approach and act as CE access points with regular trainings on CE, assessments, and diversion

Local data suggests the need and/or desire for people to live in groups for supports and survival. There are encampment groups as large as 40 individuals within our CoC jurisdiction. The CoC is working with local jurisdictions to sanction encampments that can remain undisrupted for street outreach teams to readily provide resources and supports in consistent ways to large amounts of people. The current CE street outreach has adopted the United States Interagency Counsel on Homelessness (USICH) Core Elements of Effective Street Outreach to People Experiencing Homelessness to develop its best practices. Evidence-based practices for street outreach which are taught through CoC and SAMSHA trainings include harm reduction, assertive engagement, motivational interviewing, and trauma-informed care

P4-1b. street outreach activities are connected to coordinated entry or HMIS, and

In our CoC, street outreach acts as direct arm of CE and all SNOFO applicants must act as CE Access points and participate in HMIS. Street outreach teams are responsible for conducting CE intakes and assessments and entering all CE events into HMIS. Federal and state funded programs feed HMIS by-name lists (ESG/ESG-CV, STEPH, PATH, CDGB, SSVF). External data crosswalks into HMIS include data from Psyches, Healthix, police precinct tracking, health home care coordination, drop-in centers faith-based winter shelters, and VA Homes. The CoC's HMIS Data Quality Specialist inputs external data to feed and update BNL.

P4-1c. how your CoC will incorporate new partners (e.g., business owners, law enforcement, healthcare providers) into its street outreach strategies.

The CoC undertakes consistent efforts to incorporate new and existing partners as part of street outreach strategy to engage more effectively with everyone living unsheltered. Street outreach performs organizational outreach which has led to more community referrals, less negative interactions, and less enforcement by police. Working with law enforcement on outreach as led to police precincts adopting a BNL strategy and sharing localized lists of people identified on the street, cross-referenced with, and incorporated into CoC BNLs. Police BNLs include identifying information, pictures, and last known whereabouts. The CoC also shares data with parole and health systems. Partnered outreach has also been a way to connect with leveraged supports, such as health services. The CE team is developing strategies for FQHC street medicine teams to integrate into regular street outreach to provide regular access to health screening, health access, and disability diagnoses on the street. To provide culturally competent services for effective engagement, the CoC continues to work on partnerships with translation services and immigration advocacy organizations. Organizational outreach has also included partnerships with workforce housing to move people directly from the street into employment and housing.

The community response arm of CE street outreach connects with both organizations and individual community members which are observing people living on the street and want to help. Thus far this has included concerned citizens, advocacy and volunteer groups, faith-based partners, and business owners. Developing these connections assists the CoC in identifying unsheltered individuals and leveraging supports that distribute essential items and basic needs.

An emphasis of street outreach strategy is to partner with organizations and individuals that are already trusted by people experiencing homelessness in their communities. This facilitates warm handoffs to generate rapport more easily. Examples of such partners include drop-in centers, faith-based groups (St. Vincent de Paul), re-entry support groups (COTA), and groups that are otherwise entrenched in their communities and providing vital services to those in need. Peers with experience living unsheltered either past or present have also been key partners in sharing information on whereabouts of others on the street and building trust.

P4-2a. For low-barrier shelter and temporary accommodations:

a. How data, performance, and best practices will be used to improve access to low barrier shelter and temporary accommodations,

CE street outreach provides direct transportation and accompany individuals to apply for shelter and works in direct coordination with DSS emergency services placement team to facilitate access to the most available shelter option. The CE team tracks barriers and reasons for not accessing shelter, housing preferences, reasonable accommodation shelter requests that lead to shelter placements, and shelter bed utilization for DSS shelter vs. low barrier shelter (faith-based winter bed programs / ESG-CV low barrier) and uses this data to advocate for lowering barriers to DSS shelter and for expanded low barrier shelter programs. PLE advisory input on the conditions at DSS shelters provide evidence of the barriers faced and a way to start organizing to make changes. The CE team connects participants with resources for temporary accommodations such as motel rooms paid for by faith-based organizations to increase access on a short-term time scale. Data tracked regarded access to temporary accommodations include success rates in diverting people to other resources such as shelter, rehab, living with family and/or friends and relocation and other problem-solving solutions that lead to people coming inside temporarily or permanently.

P4-2b. How data, performance, and best practices will be used to expand, as necessary, low barrier shelter and temporary accommodations, and

Existing low barrier shelter within the CoC is largely provided by faith-based programs that run only in the winter and only have the capacity to bring people inside if they present at specific pick-up locations at a specific time of day. The CoC is supporting these programs to operate year-round and expand bed capacity through funding, training, and assistance with transportation and intakes and is working on identifying geographic areas where there is not a faith-based shelter within proximity and work with local churches to use available space for overnight stays. The CoC plans to better leverage emergency motel placements available through Saint Vincent de Paul (faith-based charitable organization active locally) and the Red Cross and seek to expand length of motel stays beyond 24-72 hours.

The CoC is working with local ESG jurisdictions and eligible non-profits to apply for low barrier shelter, as well as identifying alternative funding sources (including private funds) to support shelters that do not contract with DSS for operational costs and are not required to adopt DSS eligibility restrictions and regulations. Partnership with the HIS Coalition to explore the use of pods/trailers to be built/funded and placed on church properties for emergency shelter is in progress. The state funded Rental Supplement Program (RSP) is also currently being used to pilot the use of single room occupancy temporary placements as a bridge to permanent housing.

Efforts to make existing shelter lower barrier include working with OTDA (NYS) and DSS (Nassau and Suffolk Counties) to demonstrate documented shelter needs and better align shelter design and demonstrating local costs on community and emergency response compared to costs of person coming inside. The CoC plans to partner with other CoCs that have successfully adopted low barrier shelter models and share success with our region.

P4-2c. Any new practices and activities that will be funded through an award under this competition.

The CoC is recommending TH-RRH programs that exclusively serve unsheltered participants, which is new to the region as current CoC-funded TH-RRH is exclusive to specialized populations (domestic violence and youth) which present very differently than most long-term unsheltered households locally. While street outreach programs are not new regional activities, new applicants for SSO projects are able to leverage streamlined access to mobile substance use disorder resources and medical care (CNG) or access to rehabilitation facilities (Maureen's Haven) with their other services and partnerships.

P4-3a. For permanent housing:

a. How data, performance, and best practices will be utilized to improve the CoCs ability to rapidly house, in permanent housing, individuals and families with histories of unsheltered homelessness, and

The CoC tracks the following performance metrics to ensure that unsheltered households are enrolled in housing programs quickly and efficiently: rate of successful enrollments, time from referral to enrollment, housing retention, referral acceptance by participants (with and without trials), time to move-in (compare coming from shelter vs. street, referral outcomes by living situation, and acceptance rate by time of year (indicative of weather conditions). These data illuminate any outcome disparities so that they can be addressed. Any programs that have low success in enrollments or long time periods to move in are provided guidance to remediate the situation. The CoC works closely with housing providers to implement housing first and monitors them closely for compliance.

PLE feedback is sought on a consistent basis and combined with observation of the CE team on effective strategies to make continual improvements that make sure housing programs and support services meet the needs and preferences of participants. Upon intake into CE, participants are surveyed for their housing preferences (location, unit configuration, etc.) and when a referral is made CE staff attempts to meet those preferences. When referrals are made, all attempts are made to match participants with accessible units. A dynamic prioritization strategy to ensure placement appropriateness increases success of referrals. Transportation is offered for appointments that lead housing (obtaining identification, medical appointments for diagnoses) and for intakes to housing programs. Flexible intake strategies are encouraged such as flexibility in meeting place, time to complete the process, and other accommodations, to make sure the participant is comfortable, and the intake goes smoothly. Roommate matching attempts to facilitate successful placement. Trial stays are offered to allow participants to make informed decisions about accepting referrals.

Moving people inside rapidly requires removing barriers for participants using best practices such as a streamlined referral process through HMIS, acceptance to programs based solely on eligibility (housing first, no screen outs), flexibility of housing providers when filling referrals (time to locate participant, unexpected challenges with enrollment), and using an assessment that prioritizes those with high barriers (including health outcomes). CE staff works directly with participants to remove barriers by providing highly mobile housing-focused case management, connection w/ mainstream benefits (team has a SOAR-certified benefits specialist for more successful applications), providing access to phones or tablets, and working with participants to obtain ID, income verification, diagnosis documentation. Prioritization of households by length of time homeless ensures that those with the greatest barriers to housing receive the greatest amount of assistance.

Street outreach strategies such as trauma-informed engagement, critical time intervention, assertive/progressive engagement, and rapport building, tenant preparedness guidance represent best practices for

engagement and moving towards housing for people living unsheltered. The CE team's work to engage landlords through building relationships, providing education on the challenges faced by people coming off the street, and encouraging landlords to bypass credit and background checks provides alternative pathways for moving people off the street without a housing program.

P4-3b. The CoC will expand housing focused street outreach with new partners, including those who provide medical and/or psychiatric services to move people more rapidly off the street. Moving from centralized CE to distributed access points (both by geography and community placement) for people living unsheltered provides more options to access assistance towards housing. With all recommended programs under the SNOFO being funded, capacity will be increased from one CE outreach team to four. This will provide **s**treamlined access and advance equity by providing multiple options.

Regional gaps analysis performed in preparation for the annual funding round indicated a need for an expansion of permanent housing capacity that meets local needs by having non-restrictive eligibility. The availability of additional funding for new programs with the SNOFO prompted our CoC to increase outreach efforts to new and previous applicants to create TH-RRH programs and PSH units to more rapidly house people living on the street. Housing preference data demonstrated where unsheltered people are presenting and intend to live, guiding the outreach strategy to target organizations within those communities to address localized unmet needs and increase acceptance of referrals to permanent housing. Advocating for the TH-RRH model to provide low barrier access to shelter/crisis beds and connection to permanent housing led to several applications for that program type to serve the unsheltered population. The CoC is seeking to expand permanent housing capacity further by coordinating with PHAs for set aside vouchers to move unsheltered directly to permanent housing or bridge from RRH or PSH to voucher for sustainability. Bridge housing was shown to be a successful strategy for rapid moves to permanent housing with the EHV program, which was able to successfully move on participants from RRH to a voucher. Plans are in place to increase landlord engagement capacity and available landlord incentives to have additional pathways to permanent housing for unsheltered participants.

Regional best practices include trainings on how to document and report street homelessness, as well as tracking full homeless histories (with all episodes and breaks) in HMIS. Together, these practices assist in prioritization efforts to move those with the greatest length of time homeless, and likely the greatest barriers to exiting homelessness, into permanent housing quickly. The data demonstrates the need for permanent housing expansion, while documentation requirements allow for a better understanding of how homelessness is presenting in the community and thereby the needs of participants.

P5-1. In almost all cases, any low barrier shelter/other temporary housing, and PH that is low barrier is desirable to most people on the street. However, almost all shelter goes through DSS is high barrier and most PH is specifically funded to exclusively serve very small percentages of those on the street and within the local homeless population (i.e., Veterans, persons with HIV/AIDS). All low barrier shelter programs that have operated on LI fill 100% of beds immediately and then often are over capacity to the extent possible. This has been evidenced in our region by temporary winter shelter programs. These programs were full immediately, even with inflexible admission processes that required daily re-admittance and sobriety requirements. All PSH beds that do not require highly restrictive eligibility and use housing first approaches are all filled immediately. It is well-documented locally, and continually proven that adding any low barrier shelter or PH that is housing first will immediately be utilized.

Our approach is most directly guided by people living on the street in our community and PLE Advisory groups that have lived expertise living on the street on LI. Our strategy is specifically to build capacity in the ways that people on the street explicitly state very consistently can meet their needs and preferences. Under the SNOFO, our CoC is applying for PSH, TH-RRH, and SSO projects to outreach people on living unsheltered and enhance permanent housing capacity to expand the range of housing resources our CE team can offer. These projects would by-pass the barriers unsheltered households face when seeking shelter and/or housing via other avenues.

Many households living unsheltered not interested in shelter through DSS to come inside, have been assessed as needing PSH to meet their needs, and are amenable to PSH that meets their preferences. With housing first PSH, our current gaps analysis projects that it will take over 10 years to house all chronically homeless single adults presenting in the region. Increasing PSH capacity would increase access to most sought resource for chronically homeless unsheltered

population. PSH applicants for the SNOFO (HALI and STY) will be offer units and services in specific marginalized communities with high rates of street homelessness (Central Islip / Wyandanch).

TH-RRH scale up through SNOFO will only provide direct temporary low barrier housing access to approximately 1/5 to 1/8 people on the street, depending on the time of year (in winter, low barrier bed capacity increases with faith-based winter programs and is when street homelessness rates are lowest locally). As demonstrated by winter shelter programs, these beds would fill virtually overnight and remain at capacity. Success of this program model under this SNOFO would demonstrate that RRH could work for single unsheltered adults in the community, where it has already been shown to work for families locally. Shifting the percentage of low-barrier shelter options by adding TH-RRH capacity can demonstrate effectiveness of non-DSS shelter to reduce unsheltered homelessness, providing evidence for advocacy strategy to change barriers for emergency shelter and prove effectiveness of alternative program models

Increasing housing-focused street outreach through SSO projects will help to identify more households on the street, provide more frequent and localized engagements, and provide streamlined housing referrals for those prioritized. One applicant for SSO will directly provide medical services (CNG), allowing more unsheltered households to overcome barriers to housing such restrictive eligibility requirements (SPA) or otherwise require documented disability (all PSH). Greater capacity would also allow for enhanced ability to engage in diversion/problem solving with households that are not amongst those with the greatest barriers to exiting homelessness and have other resources and/or support systems available to them.

CoC Planning funds under this SNOFO will be used for capacity building, creating, and strengthening partnerships to leverage the supports and resources needed to ensure connections to all housing, health care and support services needed/desired for people to obtain and maintain permanent housing. These funds will enable enhancement of specific tracking of success rates within programs and provide more intensive support with program implementation and operations for many first-time CoC-funded partners. CE planning capacity would need to increase to respond to necessary changes to coordinate and track referral rates that would increase significantly. Currently, approximately 55 unsheltered persons are referred to PH through CoC/ESG PH per year. Added SNOFO capacity would more than double annual referrals to PH for this population. By-Name List tracking and case conferencing will also need to become more frequent and more robust to coordinate street outreach and referrals.

P5-2a. All programs approved by the Ranking Committee were required to have non-restrictive or chronic-dedicated eligibility requirements to meet threshold ranking criteria. Bonus points were awarded for serving entire CoC geographic region to be as flexible as possible in meeting client needs/preferences. All CoC programs are required to be housing first, taking a “screen in” approach and make sure that participants are not screened out for income, sobriety, etc. For unsheltered participants, CE street outreach staff accompany clients to intake to ensure that housing providers are using a housing first approach and advocate on the clients’ behalf. This has been shown to be effective locally to ensuring referrals lead to enrollments and housing for unsheltered participants.

P5-2b. The CoC has adopted a new prioritization with stipulations specific to any programs funded under the SNOFO. All SNOFO projects will be prioritized households currently living unsheltered with the greatest length of time homeless. Street outreach already provides housing-focused case management, and the number of CE access points will increase with newly funded SSO projects. Unsheltered households will have multiple ways to access CE ways that meet their needs and that are comfortable for them. At least one of the new SSO projects will be incorporating a peer model and the CoC will be enhancing support for other providers on how to implement a peer model to rapidly build rapport, work through barriers, and increase number of engagements - which is especially critical for the unsheltered population. The CE referral process will be changed to move people more quickly into permanent housing by dropping the requirement for documentation of permanent disability at time of referral. Instead, the CE team will work with PH providers to obtain documentation post-enrollment per HUD requirements (tk days to document). Our CoC’s street outreach team has shown effectiveness in referring participants to SPA, but at slow rates due to restrictive eligibility requirements which can increase risk of mortality for unsheltered households. Street medicine partnered with street outreach (in-house for CNG, leveraged for other projects) will streamline referrals by reducing barriers for SPA by providing greater access to psychiatric care. The CE team has developed and plans to expand a helpline service which acts as a streamlined referral source, connects participants to resources, and helps to build community trust. This allows unsheltered participants to connect with CE faster and more directly than previously.

P5-3. All street outreach, present and planned with SNOFO funds, require a housing-focused case management component that is directly connected with the CES. Strategies include working on housing applications, helping participants to obtain required documentation, connecting them to benefits and/or employment, and connecting them with needed medical services necessary for better health outcomes and eligibility documentation. The existing CE Street Outreach team was designed specifically based on the feedback of people experiencing homelessness and to specific meet the unmet community need of offering housing-focused case management to people on the street. In almost all cases, people on the street are aware of how to apply for DSS shelter but are either ineligible or do not access shelter because it does not meet their needs and/or they feel safer on the street. Therefore, in most cases, to get someone off the street, it requires connections to permanent housing programs that people overwhelmingly are interested in and can better meet their needs.

The street outreach strategy for housing-focused case management involves meeting people where they are at on the street including encampments, train stations, campgrounds, and places people the parking spots of people who are living in their vehicles. All people engaged are made of the resources available to them and assessed for length of time they have been homeless, which determines how they will be prioritized for housing resources. A newly launched CE assessment is phased, with sections for safety concerns, problem solving/rapid resolution, and collection of information about barriers and vulnerabilities. For those experiencing safety concerns from threats of domestic violence, the CoC has implemented a DV CE-SSO project, which engages those actively fleeing violence/trauma and connect with to services. Households engaged that have been homeless for over one year are assigned a housing-focused case manager. Housing-focused case management involves an intensive process of building rapport, understanding someone's needs and preferences for housing and services, navigating restrictive resources, applying for housing, finding programs willing to accept someone coming off the street, and then transitioning them into permanent housing and making sure support systems are in place that make it more likely that the person remains housed. Engagements towards this end are regular, on a weekly or biweekly basis, and each meeting aims to work on a tangible step of the household's housing plan. These steps often include providing transportation to government offices to obtain identification, doctor's appointments to document disability, and housing program intakes. The existing CE street outreach team has two components, a group of chronic-dedicated housing focus case management staff (described above) and a community support staff. The community support component focuses on diversion work such as family and/or landlord mediation, temporary placements in motels, and connection with community resources. The community support staff also work to build partnerships with community members and organizations to leverage supports for people experiencing unsheltered homelessness for less than one year. This staff is also supported by and receives referral from the CE helpline, which identifies people in the community at-risk or experiencing homelessness.

P5-4a. Street outreach staff work directly with clients on obtaining various forms of identification by helping with paperwork, providing transportation, and accompanying participants to necessary appoints and acting as an advocate as needed. Community partnerships and resources are leveraged as needed to assist in the process of obtaining identification. Street outreach engages in dynamic problem solving to overcome barriers and can provide unofficial photo identification as needed. CE access points tasked with removing barriers related to documentation such as accepting self-certifications of street homelessness. The CoC advocates for housing providers to create more flexible requirements regarding documentation wherever possible.

P5-4b. Housing navigation services are provided via housing-focused street outreach, diversion and rapid resolution from street outreach or helpline staff, and landlord engagement activities. Diversion includes connection to one-time assistance funds (such as DSS one-shot), family re-mediation, and other rapid resolution solutions. Landlord engagement activities help connect those with resources to pay for housing on going or those who are connected with a voucher with support towards locating and securing units. The CoC is developing a flexible fund for landlord incentives and has been working on building ongoing relationships with landlords as part of the EHV program. Availability of psychiatric staff with expanded street outreach (described further below) streamlines diagnoses required for SPA referrals.

P5-4c. The CoC has been developing partnerships with healthcare providers and FQHCs to provide health services to people living unsheltered. This includes developing street medicine services to provide treatment to people on the street without the barriers of transportation and considering the instability inherent to living unsheltered. Street outreach teams also provide transportation to health care appointments that are related to housing, such as psychiatric evaluations, and develops relationships with providers to facilitate the process. One applicant for SNOFO funding within our CoC is a mental health care provider with an established track record of providing mobile counselling and substance

abuse treatment services. By adding a street outreach team, this agency will be able to provide streamlined treatment options and diagnoses necessary to meet eligibility requirements for the people their team and other street outreach teams within the CoC engage. The CoC also places emphasis on connecting people with health care benefits through having a benefits specialist and providing SOAR trainings. All CoC providers are encouraged and supported in helping participants apply for Medicare and/or Medicaid as applicable.

P6-1. People with lived experience (PLE) were recruited w/ targeted outreach from existing CoC network including current and former participants in housing-focused case management and emergency housing voucher (EHV) supportive services. CE staff were asked to speak with current and former clients about interest in joining a PLE advisory group. CoC planning staff followed up with communication method that best fit their preferences (phone call, text, email) and explained the purpose of the group and asked about PLE availability for meetings (in-person, virtual, or hybrid). Meetings are scheduled outside of business hours to allow for greater participation rates based on PLE feedback. Through targeted outreach, a group of different types of experiences (unsheltered, sheltered, single adults & families) and identities (race, ethnicity, gender) were sought to form an advisory group that meets monthly. Group members suggested additional PLE for targeted outreach. PLEs are informed, when outreached, that they will be compensated for their time, in the ways that best meet their needs and preferences and can shape group ground rules, goals, and action steps. The CoC partners with local social media group (LI Connections) to recruit additional PLE on social media. Continued outreach takes place during CoC participation in advocacy events including NAEH's Capitol Hill Day. CoC tapped into trusted local groups and networks involved in advocacy, equity work, support networks, recovery, re-entry, bereavement, and resource sharing for continued recruitment. Additional efforts include partnering with local pastors and faith-based groups, planning focus group discussions at various drop-in center locations across Long Island and coordinating with local youth partners that have youth advisory groups.

P6-2. PLE advisory group members are actively encouraged and supported in seeking leadership roles in CoC, including on CoC Governance Board. The CoC Governance Board already has the most voting seats designated for PLEs, but as part of a CoC Restructure the number providers on the board will be reduced and will focus on better balancing power within the GB and other committees and groups in a way that is more inclusive. All CoC groups have the goal of creating liberated spaces that shift power and decision-making significantly to PLEs. PLE are involved in all CoC Committees including the Ranking Committee, Coordinated Entry Steering Committee, and Street Outreach Committee as voting members with the ability to make decisions on policy & procedure. A notable example of this is the creation of a new CE assessment tool in the past year which was developed with the PLE on the CE Steering Committee and revised with the input of PLE connected with CE (past and present). The PLE advisory group can review policies before implementation and submit considerations for procedural changes. In most meetings, the associate director of LICH (the CoC's Collaborative Applicant and HMIS Lead) and CoC planning staff are available to share background and contextual information on existing policies and procedures and to elevate concerns to leaders of CoC-funded programs, CoC committees, and others outside of the meetings. The PLE advisory group will be involved in upcoming CoC Planning activities, including development of best practices and principles on how to support unsheltered populations, CoC-funded programs monitoring process, and strategies for the upcoming PIT count.

P6-3. PLE are involved in street outreach and the unsheltered PIT count. This involvement has influenced the CoC's move to adopt peer models for street outreach in the past 2 years. This shift has involved moving focus away degrees as measures of competence and towards lived experience, for all roles within the Coordinated Entry team. In the local CoC competition for the NOFO and SNOFO, projects were awarded points for involving PLE in staffing, leadership, program design, feedback, and staff training. The CoC encourages all projects to adopt peer models and is planning to provide educational support and technical assistance to help programs achieve this in an equitable and non-exploitative way. TAC, our CoC's technical assistance provider, will provide facilitation and research. This will include training on supporting PLE in delivery of services with support of agencies that have established and effective PLE involvement in staffing and leadership. Part of the CoC's strategy to connect people experiencing homelessness to employment and increase their income is to assist them in working in the delivery of homelessness services. The CoC plans to work with programs on developing leadership among program participants to take on responsibilities towards the delivery services as a pathway to employment (ie. PSH participant taking on more house management responsibilities) and connect them with local support and advocacy groups.

P7-1. Our CoC has identified gaps in geographies and populations served by the homeless system by evaluating the current strategy in view of feedback from communities, including people with lived experience of homelessness and those who are currently homeless.

There are several known areas in the CoC's geography which have been covered disproportionately with the number of people experiencing homelessness due to the restrictions on existing street outreach programs. NY-603 CoC contains two counties, Nassau County, which is over 160 sq. miles, and Suffolk County, which is over 900 sq miles in land area. Most funding for outreach in Suffolk County, despite its large area, have largely restricted street outreach activity to a 260 square mile area based on which ESG jurisdictions prioritize and fund street outreach activities and which did not. This has left a large area either uncovered or with only sporadic outreach efforts possible with current street outreach capacity. One of these areas includes the East End of Long Island, which is a large, remote, sub-rural area, with high rates of tourism/traffic and a limited transportation infrastructure. For outreach to take place in the most remote areas, even the outreach team based in the East End need to dedicate a full day of travel to the effort. Other more centrally located teams simply do not plan outreach to these areas on any regular basis due to logistical constraints. Expansion of the East End street outreach team would be possible with funding of one of the programs recommended for funding in this application, Maureen's Haven SSO, a program with a proven track record for housing unsheltered households. Other geographic regions left out by street outreach restricted by jurisdiction and notably excludes areas with high rates of poverty, homelessness, and high racially marginalized populations, could be covered with other non-restrictive street outreach funded with this opportunity (HALI & LICH's programs). Notably, HALI's street outreach program would be headquartered in the epicenter of a high-need, under-canvassed area and operates with a peer model.

Other populations known to be underserved are due to differing logistical constraints in the current implementation of homeless services that can be addressed with enhanced partnerships and strategies possible with greater street outreach capacity. A primary area for growth is in serving the large population of people on the street that primarily speak Spanish and do not have citizenship status. Language barriers, cultural barriers, and difficulty building trust due to wariness of government has made outreach to this population that is living unsheltered less successful. Greater barriers to exiting homelessness, such as lack of eligibility for shelter and mainstream resources, present further challenges towards successful outcomes. LICH's street outreach team has partnered with immigrant advocacy groups, faith-based, leaders, and Spanish fluent community members to make outreach more effective, but with enhanced staff capacity this effort can flourish into a streamlined referral system. Another underserved community in the region are Indigenous communities on tribal lands. Currently street outreach does not access tribal lands and there is no Coordinated Entry access point at a tribally designated entity. Through outreach for the SNOFO, the CoC has worked more closely with a local tribe, which will help begin to bridge the gap in services accessibility to this community. Underserved populations have further been identified by the CoC from community input, especially from people with lived experience of homelessness. People with lived experience have identified both underserved communities and how homelessness presents in different communities. Some examples of this are reports of people living in abandoned homes or structures with hazardous conditions, often in racially marginalized communities or in former institution settings. People experiencing homelessness under these conditions are harder to identify with currently employed street outreach techniques and often pose safety risk for outreach workers. Continued relationships with PLE will help enhance street outreach strategy. Currently implemented improvements such as using satellite imagery to locate encampments previously unknown or not easily seen by accessible points has already helped identify areas that are underserved and helps address safety concerns.

The CoC additionally maintains an awareness of underserved populations through up-to-date knowledge of restrictions that systematically exclude groups from accessing services. Key among these are services restricted by gender, which leaves out individuals that do not identify as a man or woman as well as adult mixed-gender couples. Temporary shelter options, including several of the winter shelter programs, only offer availability to single men. Single gender congregate shelter is the only shelter option for single adults and PSH for single adults is similarly limited by gender. PSH and SPA housing have restrictions based on disability diagnosis, which is dependent on health care access that equity analyses show leaves behind BIPOC.

P7-2. Racially marginalized communities, which includes households that identify as black or African American, Indigenous, and Hispanic or Latinx, present to the homeless service system in several notable ways. Racially marginalized individuals are less likely to engage with street outreach workers from outside community. Making these connections

often requires strong partnerships with community leaders to build trust. Faith-based leaders are especially influential, especially in Hispanic communities. The CoC as an entity is often viewed as government agency by communities that have been systematically marginalized by government policies and programs, leading to a baseline level of distrust. When approached by street outreach workers, members of these communities are more likely to not engage. These households are more likely to connect solely with local resources in their community and only engage with faith-based homeless services. Although racially marginalized PLE report high levels of domestic violence within their communities, there are fewer self-reports of domestic violence to authorities and fewer connections with Domestic Violence Coordinated Entry (DV CE). Additionally, in racially marginalized communities people experiencing homelessness may not meet HUD's homeless definition. According to people with lived experience, people in these communities are more likely to be couch surfing/living doubled up in overcrowded living spaces, which often does not qualify them for CoC funded services.

If engaged with CoC services, racially marginalized households face further barriers in service delivery which are often due to systematic racism and/or oppression. These households are more likely to be viewed as service resistant and more likely to be discharged due to 'lack of compliance' or have failed enrollments into programs (such as RRH). When looking for units as part of a RRH or voucher program, these households have increased difficulty due to housing discrimination. People looking to access services after re-entry from jail or prison, which are disproportionately BIPOC, are underserved due to being screened out of all program types for criminal history and due to lack of access to resources. When living unsheltered, these individuals are often harder to reach because they are less likely to have phones. People with disabilities are another group that are underserved by the homeless service system. They are less likely to access shelter or housing options due to bed/unit configuration that is unable to meet their accessibility needs and cannot qualify for PSH due to lack of access to healthcare and/or being undiagnosed or underdiagnosed. When offered shelter, people with disabilities may decline because they are unable to take their service or support animal (without extreme resistance from shelters). When CE seeks to place people with mobility related disabilities into PH, it can more than three times as long, as most housing stock on LI are suburban homes that often have stairs.

P7-3. Local strategies include targeted street outreach and capacity building, alignment of staff with populations served, alignment of resources to meet needs and preferences, training/support, community partnerships/enhanced coordination, PLE feedback, and targeted universalism.

Street outreach has moved away from using community referrals to prioritize canvassing efforts by location, as this led to under-canvassing in racially marginalized communities, and instead moved towards aligning outreach efforts with identified gaps communities reached. Partnerships have been leveraged in marginalized communities to build trust and rapport, and to identify further people living unsheltered. This has included partnerships with organizations with Spanish-language services, immigration advocacy organizations, faith-based leaders, and local advocacy/support groups, as well as working with PLEs. For SNOFO funding, the CoC recruited applicants that were already trusted by local marginalized/underserved communities. Hand Across Long Island (HALI), an applicant for street outreach and PSH funding, operates with a peer model and is well trusted in the communities surrounding their headquarters which contain a large population of racially marginalized households. Maureen's Haven, an applicant for street outreach funding, works closely with a Hispanic advocacy group (OLA) to better serve the community surround its home-base which has many Latino immigrants that work on local farms and often face housing instability. Through the recruitment process, the CoC also furthered its relationship with a local tribal nation and is committed to support expansion of services and housing available to tribal members.

The CoC is working to enhance coordination with institutions where people (including many racially marginalized individuals) cycle in and out, often exiting to homelessness, such as hospitals, jails, and rehabilitation centers. Other street outreach techniques such as enhanced hot-spotting, intel sharing on known locations, case conferencing, and cross-referencing with PLE knowledge, used to identify and engage people on the street that are often not connected to homeless services.

Part of the CoC's strategy to reach those underserved by the homeless system is to advocate for new housing programs and supports which are more aligned with needs of these populations. This has included identifying unit configurations such as single room occupancy units (SROs), non-congregate shelter options, and programs and/or units that are not restricted to single adults by gender which can better accommodate people with disabilities, transgender or gender non-conforming people, and multi-adult households. An example of successful advocacy on this front has been a

development under the NY State PSH program (ESSHI) which provides single units for adult households 55+ with no gender restriction and can accommodate couples. The CoC is currently supporting the work of a local tribal nation to develop tiny homes on tribal land. During the local competition, the Ranking Committee considered whether SRO or private rooms would be offered, as well as whether accessible units would be available, and awarded points accordingly.

TH-RRH was identified by the CoC as a program model better meet the needs of racially marginalized communities that have higher proportions of people denied shelter/housing due to criminal history or ineligible for shelter due to citizenship status by providing low barrier beds that can quickly get people inside. This model also allows people to stay in their communities of preference with the RRH portion of the program. Advocacy for this model was a big part of recruitment efforts for SNOFO program applications, especially with community organizations in marginalized communities that are already engaged in work to rehouse people outside of CoC programs.

To better align existing programs with the needs of underserved populations, the CoC offers support with operation of existing programs and sets priorities. This includes trainings available to CoC program staff, such as gender equity, racial equity, cultural competency, trauma-informed care, immigration law, engagement strategies, and training on how to conduct assessments equitably. The CoC has recently prioritized PLE involvement at every level of service delivery from peer model street outreach to leadership through ranking criteria in local competitions and planning to provide support on how to better involve PLE. Serving marginalized communities through targeted universalism approaches and doing diversity, equity, and inclusion work is also prioritized. The CoC is enhancing partnerships with PLE by creating PLE advisory group, partnering with PLE for NAEH Capitol Hill Day, and recruiting more PLE to serve as peer CE staff.

Other parts of the CoC's strategy include combating housing discrimination, enhancing housing search resources, considering impacts on marginalized communities and geographic placements of housing unit development, and efforts to decriminalize homelessness. These all serve to gain community trust and reduce trauma for people experiencing homelessness. Additionally, a new CE prioritization policy & assessment address barriers resulting from inequities.