CoC Plan to Serve Persons Experiencing Homelessness with Severe Service Needs

CT BOS CoC Plan to Serve People Experiencing Homelessness with Severe Service Needs

Prepared October 10, 2022

P-1c. Landlord Recruitment.

P-1c.1: CT BOS employs a multi-pronged strategy for landlord recruitment:

1) **Landlord incentives**. Offering incentives to participating landlords, including double security deposits and guarantees, as well as access to a risk mitigation fund of an additional $1000 for damages in excess of security deposits. Expanding landlord incentives via municipal funding. Providing supports in each Coordinated Access Network through Housing Navigators that offer housing stabilization services other tenants do not have and incentivizes landlord participation.
2) **Successful partnerships**. Leveraging individual providers' previous successes with landlords, i.e., maintaining stable tenancies through appropriate levels of client support and responsiveness to landlords re: tenancy issues, to deepen existing relationships and benefit from "word of mouth" and existing landlord recommendations to recruit new landlords. Recognizing landlords who have partnered with the CoC.
3) **Consistency**. Establishing a single point of contact at service provider agencies so that landlords have the peace of mind that they can reach someone who is able to consistently resolve their ongoing and emergency issues and get answers to their questions.
4) **Marketing**. Actively marketing to landlords on their "turf" (e.g., attending Landlord Association and Realtor Association events)
5) **Dedicated staffing**. Hiring or designating staff dedicated to landlord recruitment, engagement, and retention, to ensure consistent support for landlords, recognizing that they are a key component of all rehousing successes.

Vigorous advocacy with landlords has resulted in successful rehousing efforts across the CoC's geographic area. Because landlords feel they are supported, they are more likely to give people a chance. CT BOS is continuing to work with the CANs to develop a real estate industry-connected landlord recruitment position to attract landlords and address their concerns about an individual's ability to be successful in their unit. Dedicated housing location staff who can demonstrate long-term commitment to landlords has made this marketing more successful; however their remain areas where the CoC struggles to identify units. CT BOS will continue to work with the CANs to develop designated real estate industry-connected landlord recruitment positions to attract landlords, address their concerns, and identify units in areas that have been historically challenging, including many small towns and rural areas in the State.

P-1c.2: Within CT BOS, six Coordinated Entry sub-regions were established in 2014 to streamline the referral process—these are called Coordinated Access Networks (CANs) which cover 100% of the CoC's geography. Within each CAN, over the past 3 – 5 years, there has been a growing adoption of more centralized models of landlord recruitment and engagement, with Coordinated Entry-participating service providers and the CAN lead agencies collaborating to create larger economies of scale in landlord outreach. For example, in 2020, the Greater New Haven CAN created a Landlord Engagement Team that led to hiring a landlord liaison. This liaison is tightly integrated in the CAN, providing resources and fielding needs related to housing units and landlords. The CAN and liaison establish respectful relationships with landlords while protecting tenant rights, averting evictions and other types of housing loss. Other CANs and the State of CT are applying lessons learned from this initiative to continue to evolve their landlord and unit identification process for tenant-based rental assistance programs. In addition, individual agencies have dedicated certain staff to "housing location" activities, including searching for appropriate units, setting up viewings, managing landlord relationships, and troubleshooting tenancy issues.

P-1c.3: Going forward, CT BOS will be using its By-Name-List (BNL) data to establish unit acquisition targets for each CAN across the state. Over the course of the pandemic, units have become more difficult to locate, severely impacting the length of time between a client being matched with a housing resource, e.g., rental assistance through RRH, PSH, or a Housing Authority voucher, and the client moving into a unit. CT BOS has standardized BNL policies and procedures and database infrastructure to store BNLs and analyze historical data

to establish trends in the number, type, and size of units generally needed in each CAN. This trend analysis will establish a baseline unit acquisition "need" to guide CANs' landlord recruitment efforts. As CT BOS matures this process, it can begin to set more ambitious goals that move performance closer to the statewide Emergency Shelter Length of Stay target of 45 days (avg).

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

P-3.a.1: Street outreach (SO) is organized into 6 regional geographically-based teams that operate in each of the Coordinated Access Networks (CANS). CT developed this strategy more than 5 years ago and has been refining it since. Uniquely braiding federal PATH and CARES Act resources with state funds and partnering with Veteran, HIV, youth and other outreach services, the teams focus on engaging unsheltered people and connecting them to support services, low barrier shelter and permanent housing across the CAN geography. The CoC leveraged SO improvements with the addition of CARES Act-funded teams, and the adoption in 2021 of state-wide Street Outreach standards for all PATH and State-funded Street Outreach teams. Veteran Outreach operates out of the VA Medical Center, and street outreach teams coordinate to refer populations between the teams. Lessons learned when the State of CT was ending Veteran homelessness, have been applied to ensure coordination among the CARES Act-funded and PATH-funded teams. Additionally, there are locally funded outreach teams in four of the larger municipalities around the state with whom the CAN-based outreach teams also coordinate. The SO teams collaborate to produce and regularly update a single coordinated outreach plan for each CAN that details the schedule (date/time), responsible agency, assigned staff, and locations for (1) physical canvassing known locations in each CAN with a high probability of locating people living unsheltered; (2) outreach conducted in high traffic areas, i.e., soup kitchens, day shelters, drop-in centers, libraries, and other relevant places; (3) phone/email outreach to towns where canvassing and onsite outreach is not feasible.

Outreach teams in the CAN are responsible for ensuring that this plan covers all areas of their CAN geography and that plan(s) are informed by current information about patterns of unsheltered homelessness. The outreach plan also addresses uncovered areas, system gaps, emergency planning, a list of supplies that outreach staff makes available to clients, and strategies for ensuring that members of the public know whom to call to get help for someone living unsheltered. All outreach teams maintain a robust list of partners (soup kitchens, drop-in centers, local businesses, police contacts, social service agencies, municipal contacts, and others) and a schedule for phoning and emailing partners to identify and locate people living unsheltered. Some examples of partner coordination include co-locating case managers at police departments in higher unsheltered volume areas, working with police departments to embed crisis clinicians, working with the State Department of Transportation and CT State Troopers to conduct outreach at bus and rail service locations across the state. These partnerships are in addition to the street outreach days/times listed below, during which outreach staff actively canvass known unsheltered locations and routinely visit high-traffic areas where people living unsheltered know that staff can be found at the same day and time each week.

To ensure coordination with partners also conducting outreach and minimize duplication of services, the outreach plan is reviewed, modified, and approved by the Connecticut Department of Mental Health and Addiction Services (DMHAS) – the administering agency for PATH funding – and the CAN planning body twice a year. Plans are also reviewed, modified, and approved by a supervisor at least monthly. DMHAS and DOH host a quarterly meeting that all street outreach teams across the CoC are required to attend, using the meeting to conduct trainings and strengthen coordination and standardization across the state. In addition, some CANs also host monthly outreach coordination meetings to review and update the CAN-wide outreach plan, coordinate any staffing or schedule changes, and ensure implementation of any statewide changes to outreach efforts.

P-3.a.2: The coordinated outreach plan ensures frequent and complete coverage of diverse locations, during business and non-traditional hours, using phone/email contacts to bridge the gap in areas where canvassing is not a good use of scarce resources. Days/times for each CAN follow: **Greater Hartford CAN-** Outreach teams canvass and visit high-traffic locations 7 days/week across the CAN, with hours starting at 6-7a weekdays and

ending at 4-5p, with on-call availability (i.e. outreach staff go out to respond to calls) until 10p. **MMW CAN-** Outreach teams canvass and visit established high-traffic locations 4 days/week across the three towns and surrounding areas in the CAN: Mondays 6-11a and 3-8p (alternate timeslot every other week), Tuesdays 9a-2p and 1-4p (alternate like Mon), Wed 9-1p (every week), and Thurs 11:30-1a (every week). **Greater New Haven CAN-** Outreach teams canvass and visit established high-traffic locations 6 days/week across the CAN, with M-F hours starting at 5-7a and ending at 8p and Saturdays 8a-2p. Due to funding constraints, outreach staff limit their canvassing to known unsheltered areas and rely on regular check-ins with community partners to alert re: new locations where people are living unsheltered. **Northwest CAN-** Outreach teams canvass 1 full day/week (Wed 9-4:30p) and visit established high-traffic locations 5 days/week at 9a. Due to very limited funding and a large geographic area, outreach workers make regular contact with community partners, including hospitals and municipal social workers, to identify additional people living unsheltered. **Eastern CAN-** Outreach teams canvass and visit established high traffic locations 4 days/week: Mon 7:30a-5:30p; Tues 9a-12:30p; Wed 7a-12:30p; Fri 12-1p. Outreach teams are limited due to the size of Eastern CAN and limited funding. Outreach workers make regular contact with Eastern CT Town and City Halls to identify additional people living unsheltered **Central CAN-** Outreach teams canvass and visit established high traffic locations 4 days/week plus every other Friday: Mon 8a-1p and 3-5p; Tues 8:30-5p; Wed 8a-12:30p and 4-6p; Thurs 10a-12:30p and 3-5p; Fri 6-7a and 9-1p.

P-3.a.3: Outreach teams across the state employ a range of best practices to help people to exit sheltered and unsheltered homelessness, including the following:

- Working with the Street Psychiatry and Street Medicine Teams from the local Federally Qualified Health Centers (FQHCs) and the CT Mental Health Center to provide as much care as possible in the locations that people experiencing unsheltered homelessness frequent;
- Working with non-traditional partners such as pride centers, Area Agencies on Aging, libraries, immigrant organizations and re-entry programs, to ensure engagement of "hidden" populations such as LGBTQ+ persons, undocumented persons, elderly adults, and persons using libraries to manage (and hide) their unsheltered homelessness;
- Using motivation-building strategies informed by Motivational Interviewing (MI) to help people examine their situation, understand their options and progress towards goals when they: have mixed feelings about change; they doubt their abilities to change; they are uncertain about whether they want to make a change; and/or the advantages and disadvantages of change are unclear.
- Working with municipal governments when encampments are identified to engage people experiencing unsheltered homelessness in case management and placing and prioritizing people on the CAN's By Name List to be matched to a housing resource, instead of regressive "encampment sweeps" that largely rely on sanitation and police services without consideration for people living in the encampments;
- Partnering with local healthcare providers so that their community care teams accompany outreach staff when they engage with clients—these community care teams are locally based, multidisciplinary groups of care providers that address medical issues and social determinants of health;
- Employing the evidence-based Critical Time Intervention (CTI) model in outreach case management to support people through the transition from homelessness to housing, connect them to resources and supports, and build skills for self-advocacy. Outreach teams use CTI to support housing stability, reduce crises, and improve behavioral health by building connections to community supports, promoting community integration and helping people to move away from crisis and develop longer-term plans to address their needs;
- Providing consistent case management from outreach enrollment through the point of stabilizing in housing, with the same outreach workers providing aftercare in housing;
- Actively participating in local Harm Reduction efforts, e.g., an Opioid Task Force in New Haven, and a Harm Reduction and Syringe Services Programs for Hartford County, two large metropolitan areas;
- Carrying Naloxone and ensuring that all outreach staff are trained to deploy this lifesaving medication in the event of overdoses; and

- Participating in a Statewide Coordinated Outreach Task Force, along with other CAN stakeholders, to maintain standardized processes, coordinate efforts, receive timely guidance from state agencies, align and ensure consistency in shelter and housing prioritization, and identify and meet shared training needs.
- Working with the CAN to make "rapid exit" funds available to support people living unsheltered to reconnect with natural supports with whom they are able to live.

P-3.a.4: The outreach plans described above include a specific engagement plan for the most vulnerable clients within the CAN, indicating specific clients who are highly vulnerable, who is assigned to engage them, and how frequently engagement attempts will occur. Targeted assignment of bi-lingual/bi-cultural staff ensures use of culturally appropriate strategies. Plans also detail how engagement of vulnerable clients will continue when staff are absent. CANs determine the targeting criteria that define "most vulnerable," including the highest vulnerability assessments, the longest length of time homeless, and medically fragile status. These clients are prioritized for heightened engagement on the street, as well as for access to shelter and permanent housing resources. Outreach projects are monitored annually, and the monitoring team selects "highest vulnerability" case records when monitoring to ensure use of engagement strategies and service intensity that is commensurate with client needs and preferences.

P-3.a.5: Within CANs, outreach teams and housing providers conduct case conferencing to ensure that people experiencing unsheltered homelessness are swiftly connected to permanent housing and provided adequate support to locate and move into a unit, including housing location services (finding units), attending viewings with clients, attending appointments and interviews with landlords, and assisting with clients' understanding of leases, tenancy requirements, and other skills associated with maintaining tenancy. These case conferencing meetings occur weekly to biweekly in each CAN. During case conferencing meetings, housing provider staff and outreach staff also troubleshoot any issues that a client or staff person is encountering in the rehousing process.

In addition to ongoing annual monitoring, in 2023, street outreach contracts will incorporate a set of housing-focused performance standards:

- % of clients exiting Street Outreach project who exited to a permanent housing location
- For clients who exited to a permanent housing location, length of time from enrollment date to permanent housing move-in date
- % of clients with an increase in income from any source from enrollment to exit, regardless of exit destination
- % of unsheltered persons encountered (regardless of enrollment) who are entered into HMIS within 72 hours of encounter

P-3.a.6: Street Outreach teams across the state employ persons with lived experiences of homelessness. These persons assist with identifying locations where people live unsheltered and engage with people who are disinclined to trust other staff who are associated with the system. One CAN contracted with five young adults who conduct outreach and engagement in the field and meet weekly with the CAN lead agency to strategize on engaging people living in unsheltered situations, recognizing that outreach effectiveness is only achieved through consistent and culturally responsive interactions. People with lived experiences of unsheltered homelessness also participate in housing location and navigation roles and in program development. Having staff with lived experience demonstrates to people living unsheltered that there is hope and a pathway to a more stably housed life. Peer staff also help break down the stigma associated with living unsheltered and help people on the street to feel more "seen" and understood.

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

P-3.b.1: The Connecticut Department of Housing (DOH), which is the largest public funder of shelters across the state, requires DOH-funded shelters to operate with low barriers to entry and continued residency. DOH monitors shelters on this requirement, covering the following policies related to low-barrier sheltering:

1. Flexible Length of Stay policies to prevent "timing out" discharges
2. Termination/Discharge policies state that "No client shall be discharged into homelessness without an opportunity to participate in a case conferencing session with their respective CAN, unless such client poses an immediate health or safety risk to themselves or others."
3. Admissions may not be based on a drug test or breathalyzer. Drug testing must not be in the policy manual.
4. Referrals must come from the CAN lead agency, which verifies that households are experiencing homelessness (to avoid shelters filling beds with persons not literally homeless)
5. Eligibility criteria, participant agreements, policies and practices all align with a Housing First approach

CT BOS has very little remaining CoC-funded transitional housing (TH), and what remains is dedicated to young people and households fleeing domestic violence. Youth-specific staff work to prioritize young people who are unsheltered for transitional housing, and the numbers of young people experiencing unsheltered homelessness remain very low as a result. CT BOS has 12 shelter beds for young people, as well as several TH projects that meet temporary needs. Within these shelter and TH projects, providers used best practices, including harm reduction, trauma informed care, and youth empowerment models. Further, young people are able to access youth-dedicated RRH and PSH projects around the state funded through the Youth Homelessness Demonstration Program (YHDP).

P-3.b.2: The strategy is effective at providing low barrier shelter, but as noted below, shorter shelter stays are necessary to enable access to that low barrier shelter for all people experiencing homelessness. The CoC successfully launched and operated a large-scale non-congregate sheltering effort in response to COVID; however, those funds are no longer available, and, consequently, most shelter has returned to a congregate model with exceptions noted below. Due to COVID-related tightening of the housing market, shelters across CT are struggling to exit households to permanent housing in a timely manner, resulting in lower shelter bed turnover, less flow through the system, and an increase in unsheltered homelessness. All CANs are currently maintaining shelter waitlists, with unsheltered households as highest priority. Families with minor children who are found to be living unsheltered, e.g., sleeping in their cars, or who are about to be unsheltered, are immediately placed in hotel rooms until a shelter unit becomes available, ensuring that no children are unsheltered.

All shelters and TH in the CoC are required to adhere to the CoC policy "Ensuring a Safe, Healthy, Inclusive, Affirming and Discrimination-free Environment for Persons Identifying as LGBTQIA+" and receive related training from the CoC annually. Shelters and TH also undertake agency-specific efforts to be culturally responsive. For instance, one agency that operates the full continuum of projects, from shelter to PSH, uses a Person-Centered philosophy and employs the best-practice methodology of "Trauma-Informed and Gender-Responsive Care," designed to empower clients while remaining cognizant of personal histories and experiences. For other populations, respite beds and medically fragile prioritization (both described below) have made some progress in reducing the numbers of unsheltered individuals who are sick, but shelters lack adequate funding to fully implement sheltering practices that address the severity of physical, mental, and behavioral health issues. More medical respite beds are needed to meet the demand.

P-3.b.3: Shelters across the state have also removed many barriers to entry over the past 3 years, with a number of "damp" shelters in operation. In such damp shelters intoxication is permitted, and individuals can leave the shelter to drink or use and return without being removed from the premises. This model is a promising practice for hardcore alcohol and drug users, but interviews with current and former unsheltered individuals revealed important lessons (e.g., a need for clearly demarcated "wet/damp" and "dry" shelter areas within shelter facilities

so that persons who are not actively using alcohol or drugs can avoid the disruptiveness of people who are actively using). This unmet need remains. More healthcare partnerships are also needed for shelters not located in major CT municipalities. During the pandemic, both sheltered and unsheltered individuals have presented with more behavioral health needs or increasing severity of those needs. Changes in the workforce due to healthcare worker burnout, coupled with an overwhelming rise in demand for these services and a pandemic-induced shift to telehealth, have combined to create a significant shortage in these much-needed services.

As described above, CT BOS prioritizes unsheltered households for shelter, and within the unsheltered population, medical fragility and other vulnerabilities are used to further prioritize. Over the past 3 years, in response to increasing medical needs and an increase in the severity of needs) in the unsheltered homeless population, shelters across the state have incorporated **medical respite** beds into their facilities. These beds provide acute and post-acute care for persons experiencing homelessness who are too ill or frail to recover from a physical illness or injury on the streets but are not ill enough to be in a hospital. This best practice model allows individuals experiencing homelessness the opportunity to rest in a safe environment while accessing medical care and other supportive services. These medical respite beds have been very successful, offering more peaceful non-congregate spaces to sick individuals so that they can recover while staff work with them to find housing. A lesson learned is that this model requires close coordination with healthcare providers and hospitals, and shelters have had to add positions to manage the coordination and service intensity.

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

P-3.c.1: CT BOS requires all projects funded with CoC resources to use the Housing First approach and has defined what that means by adopting Housing First principles that are monitored on an annual basis. For example, monitoring ensures that:

(1) Housing is not contingent on compliance with services;
(2) Tenants may only be terminated for lease violations or failure to carry out obligations under Connecticut's Landlord and Tenant Act and may only be evicted from their units per valid court orders;
(3) Services are provided post-housing placement to promote housing stability; and
(4) Grantees are not permitted to require project residents to participate in any services

The CoC's monitoring program evaluates project compliance with its Housing First Principles by reviewing leases, policies, participant handbooks, case notes, service plans, etc., to ensure that participation in services is voluntary and that participants are not denied entry or terminated due to substance use, reluctance to engage in services or treatment, lack of progress on goals, or other impermissible reasons. The monitoring team also interviews case management staff and participants to assess alignment with the Housing First model. Failure to adhere to the CoC's Housing First principles results in a finding, with specific recommendations to correct the finding. If subsequent monitoring indicates that a project is unable or unwilling to make the necessary changes, the project risks being reallocated. Through its annual renewal evaluation process, the CoC also monitors housing stabilization outcomes to ensure that participants remain housed and do not exit into homelessness.

In addition, the Coordinated Access Networks (CANs) ensure that projects are adhering to a Housing First approach, including prohibiting certain admission criteria and prioritizing rapid placement and stabilization in permanent housing. Permanent Housing (PH) projects must enroll only applicants referred via the CAN and may not reject eligible applicants due to criminal history, active or past substance use, lack of income, poor credit, eviction history, reluctance to engage in services, or other barriers. CT BOS is also leveraging landlord incentives to negotiate reductions in application criteria and plans to continue to use future incentives to lower barriers for clients with tenant-based permanent housing vouchers. These landlord incentives have been introduced in the past three years and show promise in reducing barriers, but these incentives and negotiated reductions in barriers must be scaled up significantly to meet the needs of unsheltered individuals who have been matched with tenant-based Rapid Rehousing and Permanent Supportive Housing (PSH) vouchers.

Connecticut was an early and enthusiastic adopter of PSH and built out a significant stock of nearly 5,000 units of PSH for individuals and families across the state. These early investments paved the way for the State of Connecticut to be the first state to end chronic homelessness among Veterans, and later, to end Veteran homelessness. The State of Connecticut continues to work toward ending all chronic homelessness in the state, maintaining a statewide list of fewer than 100 individuals still experiencing chronic homelessness. The State has consistently invested in affordable housing and dedicating those resources to homeless people. In this funding application, the CoC is building upon its PSH strategy as follows: CT Department of Housing has committed 55 Housing Choice Vouchers and over $12 million in CT State Bond Financing as leverage for permanent supportive housing units that will be a critical part of this plan. Other leverage for PSH in the CoC has come from state bond financed and Low-Income Housing Tax Credits (LIHTC) projects.

CT BOS will be maximizing its new and existing resources through advocacy with landlords, working with CANs to attract landlords and address their concerns about an individual's ability to be successful in their unit. This marketing requires the kind of long-term commitment to landlords that our dedicated housing location staff provides. Going forward, CT BOS will begin using its By-Name-List (BNL) data to establish unit acquisition targets for each CAN across the state to ensure that every available voucher is leased up as quickly as possible.

P-3.c.2 & 3: Each CAN maintains a prioritized By-Name List (BNL), and unsheltered status is one of the priority factors, though Length of Time Homeless (LOTH) is the primary prioritization factor. Whenever possible, people living unsheltered who have been prioritized for PSH or RRH are housed directly from unsheltered locations, as evidenced by CT BOS's Longitudinal Systems Analysis (LSA) data that shows that 15% of clients enter RRH from the street, and 8% of clients enter PSH from the street, without a prior shelter stay. CT BOS began using RRH to house the most vulnerable households in 2019, utilizing a progressive engagement and Critical Time Intervention (CTI) model. CT BOS has funded regular training and Communities of Practice for housing staff to ensure fidelity to CTI.

Re: culturally appropriate access to housing, young people are able to access youth-dedicated RRH and PSH projects around the state. All projects in CT BOS adhere to the CoC policy "Ensuring a Safe, Healthy, Inclusive, Affirming and Discrimination-free Environment for Persons Identifying as LGBTQIA+" and receive training from CT BOS annually. Shelters and TH also undertake their own efforts to be culturally responsive. For instance, one agency that operates the full continuum of projects, from shelter to PSH, uses a Person-Centered philosophy and "Trauma-Informed and Gender-Responsive Care," designed to empower clients throughout the process, while remaining cognizant of personal histories and experiences. Areas with large latino/a/x populations have added bi-lingual staff and connections to culturally-specific services and supports. The CANs and CT Coalition Against Domestic Violence (CCADV) also work closely together, with CCADV playing a key role in standing up RRH for survivors, and full alignment with CANs to prioritize survivors who also have other characteristics or situations that indicate a need for PSH. CCADV's close partnership has resulted in increased responsiveness in RRH and PSH projects, regardless of whether they are specifically for survivors.

P-3.c.4 In the past 3 years, the CoC launched a significant RRH program for DV survivors. That program is designed to leverage the unique capacities of multiple partners as follows: CCADV is responsible for project management, coordinated entry, policy development, training, and leadership of continuous quality improvement efforts; a single homeless service provider in each region is responsible for housing location; and DV service providers are responsible for care coordination, safety planning, and housing stabilization supports. The CoC has also implemented new approaches to centralizing housing location for other target populations as described in section P-1.c. Lessons learned include how to take advantage of economies of scale and increase effectiveness of housing location through staff specialization by centralizing core programmatic functions.

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

Street Outreach- P-4.1.a: The CoC has engaged in multiple rounds of system modeling for young people experiencing homelessness, as well as a robust investment in 2022 to determine the size and resource array of a statewide homeless service system that meets the needs of all persons experiencing homelessness. This 2022 modeling exercise will be used to drive CT BOS investments and state investments in 2023 and beyond.

When SO teams are appropriately staffed (using funds from this NOFO), the most vulnerable unsheltered clients will benefit from more robust implementation of best practices, e.g., more intensive motivation-building and Critical Time Intervention (CTI) methods. SO workers already coordinate with CAN diversion specialists, and housing navigators to align efforts, facilitate case conferencing, and coordinate all efforts associated with households who are not yet in shelter. These NOFO funds will be used to support CANs to build out service hubs, as described in P-4.2 below, to meet immediate basic needs, and work with clients to obtain disability verifications, fill out benefits applications, collect vital records (ID, birth certificate, Social Security card), meet behavioral and physical healthcare needs, and other goals identified by the client, so that outreach workers can focus on people least likely to engage and seek help from systems they do not trust. Through the combination of outreach and hubs, staff across the system will be able to successfully adhere to CTI case management.

The following metrics will be used to improve street outreach performance within the CoC:

- Number of unsheltered households with CAN enrollment without an Outreach enrollment (unmet need)
- Number and % of unsheltered households on the CAN's shelter waitlist (unmet need)
- % of clients exiting Street Outreach project who exited to a permanent housing location
- Of clients exited to permanent housing, length of time from Outreach enrollment to housing move-in
- % with increase in income from Outreach enrollment to exit, regardless of exit destination
- % of unsheltered persons who are entered into HMIS within 72 hours of encounter

P-4.1.b: CT BOS and the CANs will use performance and "unmet need" data derived primarily from HMIS to hold providers to performance standards, determine additional funding for Outreach teams to achieve more effective caseload sizes, provide targeted technical assistance and training on evidence-based practices to improve performance, and ensure that diverse populations have equitable outcomes. Evidence-based practices that CT BOS will continue to invest in include (1) Motivational Interviewing, (2) Critical Time Intervention (CTI), (3) Trauma Informed Care, (4) Permanent Supportive Housing, (5) Housing First, and (6) Harm Reduction, all of which support deeply vulnerable unsheltered people to achieve housing. CT BOS providers also rely on assertive engagement techniques and housing problem-solving/diversion/mediation as best practice methods of resolving an episode of homelessness regardless of how long someone has been experiencing homelessness already.

During the pandemic, SO and CAN staff began maintaining a single list of all households seeking shelter and/or working with a diversion specialist to find a safe alternative to shelter. These lists help the multiple SO teams and CAN staff stay aligned on current needs, client demographics (race, ethnicity, gender, age), community preferences, current living situation, client location details, contact information, which staff person is working with the client, when they were identified and verified as meeting the homeless definition, and how many days they have been on the list. With this dataset, CANs and SO teams regularly calculate unmet needs, prioritize according to CAN policies, and measure client outcomes across the CAN.

P-4.1.c: CT BOS's approach to street outreach has a built-in mechanism for reviewing and refining outreach plans in each CAN and incorporating new partners. Outreach teams will continue to be responsible for ensuring that there is a plan covering their assigned CAN and that plan(s) are updated at least monthly based on current information about: patterns of unsheltered homelessness; new resources and partners; and other conditions in the CAN. To ensure coordination with existing and new partners and to minimize duplication of services, the CAN-

wide plan will continue to be reviewed and approved by DMHAS and the CAN at least two times per year and by a supervisor at least monthly.

During the pandemic, CT BOS and providers focused on deepening existing partnerships and engaging new partners, assessing current resources and needs, and creating an evidence-informed strategy to fill gaps and more effectively achieve outcomes, including reworking the system to eliminate as many barriers as possible to people experiencing unsheltered homelessness. One big change in progress is the creation of service hubs where new and existing partners will work to engage people living unsheltered, offer convenient meeting places for clients, and work with clients to obtain disability verifications, fill out benefits applications, collect vital records (ID, birth certificate, Social Security card), meet basic living and safety needs, meet behavioral and physical healthcare needs, and other goals identified by the client.

SO teams and CANs will establish new and deepen existing partnerships, building on proven practices, e.g.,

1. New Haven SO Teams will work in collaboration with Cornell Scott-Hill Health Center's Street Medicine Team and Community Mental Health Center's Steet Psychiatry Team. New Haven's Street Medicine team provides on-the-spot medical care for people experiencing homelessness where they are—in soup kitchens and shelters, in parks and under bridges, and on the streets.
2. Multiple SO Teams will collaborate with Medication Assisted Treatment program for opioid use disorders.
3. Hartford SO teams will work with youth-dedicated providers to provide a safe, empowering, and trusting environment for young people. These partnerships include hiring young adults with lived experience to improve engagement of clients experiencing literal homelessness, improve service delivery, and promote best practices across the homeless service system.
4. Multiple SO teams will work with health care and wellness programs, Hospitals and Emergency Rooms, FQHCs, treatment centers for counseling, detoxification outpatient/inpatient care, long-term treatment and counseling for mental health and substance abuse, methadone maintenance, and employment resources.

Low-Barrier Shelter - P-4.2.a: DOH will continuously improve access to low barrier shelters by monitoring program eligibility and implementation of the requirement that all state and federally funded shelters receive 100% of their referrals from the CAN. CANs will focus on deepening existing partnerships and engaging new partners, assessing current resources and needs, and creating an evidence-informed strategy to fill gaps and achieve better outcomes. Together DOH and the CANs will use data and other information derived through monitoring, coordinated entry, and piloting of new practices to weave the safety net tighter and narrow gaps where the most vulnerable could fall through. For example, sheltering strategies will continue to be updated in response to lessons learned during the pandemic, when use of warming centers and hoteling were prevalent and it was evident that these options are more attractive to people living unsheltered who had trouble managing even the low-barrier shelters. Unsheltered households needed more accessible resources, including showers, laundry, health care, access to food, and other basic needs, and through our efforts during the pandemic, people can now access these resources in many sites across the state. Data gathered directly from persons experiencing homelessness will be used to continue to identify gaps and improve access to these critical resources.

P-4.2.b & c: The CoC is redesigning the front end of its system to respond to vulnerabilities exposed by the pandemic, proposing a system that eliminates as many barriers as possible for people experiencing unsheltered homelessness to be rapidly rehoused without expanding the shelter footprint in CT BOS. This means establishing service "hubs" that build on lessons learned during the pandemic about rehousing people directly from the street, using warming centers to meet immediate basic needs while securing housing. These hubs will operate 7 days a week. They will be conveniently located within walking distance for most people to get staff assistance, charge phones, use computers, eat, see a clinician or medical provider, get clothes or other items, and, at some hubs, take a shower and/or do laundry. These hubs will work as a network and communicate with one another regularly. Hubs will build on existing and new relationships with Community Health Centers to provide rapid access to healthcare.

The funds to support the CAN hubs are an integral part of an upcoming system redesign in which Housing Access & Stabilization Teams (HAST) are responsible for the continuum of CE services from engagement to housing. At the center of the HAST are the Diversion Specialists, tasked with housing crisis needs assessment and triage to services (street outreach, emergency shelter, flexible assistance, community resources). Given current funding levels to support diversion work, the CE is unable to offer expanded coverage to non-traditional business hours outside of some time-limited outreach staff. In addition, as the CE strives to ensure that service access is low-barrier, walk-in locations with trained staff experienced in diversion, assessment, and triage are vital to ensuring individuals who are least able to follow the sequencing of the CE system are appropriately connected to services.

The following performance measures will be applied to HAST teams:

- Number of unsheltered households active on By-Name List
- Length of time on By-Name List for all unsheltered households
- Percentage of unsheltered households on By-Name List matched to permanent housing resource
- Length of time between By-Name List placement and date of match to housing resource
- Number of unsheltered households exited from By-Name List to exit destinations listed below
    - Length of time of unsheltered households from By-Name List placement to exit (by destination)
    - Length of time of unsheltered households exiting By-Name List w/ project-based subsidy
    - Length of time of unsheltered households exiting By-Name List w/ tenant-based subsidy

Permanent Housing P-4.3.a & b: CT BOS proposes to use NOFO funding to create an additional 147 units of PSH following Housing First pillars: 1) Provide a low barrier approach to entry; 2) Focus on community integration and recovery; 3) Housing is located in neighborhoods that are accessible to community resources; 4) Efforts are made to make the housing look and feel similar to other types of housing in the community; 5) Services are designed to help tenants build supportive relationships, engage in personally meaningful activities, and regain or develop new roles in their families and communities; 6) Services are recovery-based and designed to help tenants gain control of their own lives, define their personal values, preferences, and visions for the future; 7) Retention in housing is contingent only on lease compliance; 8) Separation of housing and services; and 9) Tenant choice.

CT BOS will monitor funded projects to ensure that PSH Case management services are individualized and designed for each household, based on clinical and functional assessment of needs as well as client preference. Using data gathered through project monitoring and renewal evaluation, CT BOS will continuously update training and technical assistance strategies to ensure that case management services: effectively assist clients in: maintaining safe, affordable housing and avoiding eviction; increasing income; building independent living skills; establishing enduring linkages with clinical and rehabilitation services, including assistance with employment to support them toward achieving independence, and if applicable, to stabilize their symptoms of mental illness, addiction and/or chronic health conditions; building natural support networks; engaging in meaningful activities; taking an active role in identifying and prioritizing their needs and goals through a collaborative service planning process. CT BOS will also continuously update its monitoring, renewal evaluation, training, and technical assistance strategies to ensure that PSH providers are using an integrated system of care and effectively partnering with healthcare and other providers to meet tenants' full spectrum of needs.

Each CAN will continue to maintain a single By-Name List of households prioritized for all available permanent housing resources (RRH, PSH, and vouchers made available by partnerships with Housing Authorities). The following metrics will be used to improve performance and ensure that the CoC is rapidly housing unsheltered (and previously unsheltered) households:

- % of unsheltered households on By-Name List matched to permanent housing resource
- Number of unsheltered households exited from By-Name List to permanent housing
- Length of time of unsheltered households exiting By-Name List w/ project-based subsidy
- Length of time of unsheltered households exiting By-Name List w/ tenant-based subsidy

CT BOS and the CANs will use these data to hold providers to performance standards, determine additional funding for housing location, landlord recruitment, and RRH & PSH case management to maintain caseloads necessary for CTI, provide targeted technical assistance and training on CTI, and ensure that diverse populations have equitable outcomes.

CT BOS will employ these practices to increase the number of rehoused (formerly unsheltered) households:

1. Provision of service-intensive PSH, including supports for persons with high healthcare needs
2. Representative Payee Services: Providers and/or intermediary agencies will assist clients with disabilities by acting as an intermediary to pay bills on the client's behalf. Efforts to expand this service include identifying new partners who can serve in this role.
3. Moving On: CT maximizes its robust PSH resources by targeting permanent vouchers (Housing Choice and State Rental Assistance Program) to households prepared to move on from PSH. Because much of the PSH stock is tenant-based, the state is able to maintain its Moving On program with consistent positive PSH exits without destabilizing the household.
4. "Ticket to Work": A pay-for-success model that pays for each SSDI/SSI client helped to gain and maintain employment for a period of time. Agencies will work with eligible program participants to provide career counseling, job placement, and ongoing employment support services. Though the nationwide success rate of this program is around 1%, one agency in CT BOS averages a 30% success rate. CT BOS will work with additional agencies to amplify these successes across more of the region.
5. Pathways to Independence (PTI): Using a person-centered approach to care, our Employment Specialists (1) assist clients in job searching, writing resumes and cover letters, and mock interview (2) connect clients to employers and job opportunities, (3) prepare clients for sustained employment, and (4) address basic skills required to reenter the workforce. Our employment specialists help clients regain the confidence necessary to re-enter the workforce. They also help clients to overcome challenges such as obtaining identification, securing professional clothing, and accessing transportation that are necessary for employment. Columbus House uses a "Supported Employment Profile" in order to ascertain an appropriate course of action for an individual on the path to employment. This critical program enhances and expands services for people experiencing homelessness by providing: 1) enrollment into mainstream benefit programs 2) employment services; and 3) financial coaching.
6. CoC-wide landlord engagement: Successful rehousing efforts require vigorous advocacy with landlords. CT BOS will work with CANs to develop a real estate industry-connected landlord recruitment position to attract landlords and address their concerns about an individual's ability to be successful in their unit. This marketing requires the kind of long-term commitment to landlords that our dedicated housing location staff provides. Where landlords feel they are supported, they are more likely to give people a chance.

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

P-5.1: CT BOS will utilize the funds made available under this NOFO to further drive its system toward quickly and permanently rehousing unsheltered households across the state by building out its Street Outreach, PSH, and Coordinated Entry resources, and by using CoC Planning funds to monitor and evaluate progress and make adjustments to continuously improve performance. CT BOS has well-established networks of street outreach teams and coordinated outreach plans, but the network is understaffed to fully meet the needs of everyone experiencing unsheltered homelessness. There are too few outreach workers to dive into the intensive rehousing process that will result in an end to each person's unsheltered homelessness. Households experiencing unsheltered homelessness are already prioritized for shelter and permanent housing **(P-5.2.a)**, and this injection of funding into the system will allow for an adequate expansion of resources for these prioritized households, including 147 additional units of service-intensive PSH and additional Street Outreach positions to provide the level of care needed to build relationships among people with high levels of mistrust in the system and quickly connect them to housing resources. As the program evolves, eligibility, prioritization and coordinated entry processes will be adjusted based on lessons learned and the evolving needs of the unsheltered population to continue to ensure that unsheltered people remain the priority for homeless resources.

P-5.2.b & P-5.3: CT BOS will utilize funds from this NOFO to:

(1) Expand Street Outreach coverage to canvass areas with demonstrated need for more Outreach presence;
(2) Increase Street Outreach staffing so that all people experiencing unsheltered homelessness can be engaged and supported with fidelity to evidence-based practices, e.g., Critical Time Intervention (CTI) and Motivational Interviewing, as well as best practices like housing problem-solving;
(3) Focus Street Outreach hiring preferences on people with lived experience of homelessness, serious mental illness or substance abuse with stability in their own recovery and a willingness to self-identify as someone in recovery;
(4) Ensure that Street Outreach teams are coordinating with housing providers to support clients through the pre-CTI phase of Critical Time Intervention;
(5) Create service hubs to take on key functions so that SO workers can focus on those least likely to engage;
(6) Expand housing navigation services available to connect more people with subsidies to available units;
(7) Deepen and expand partnerships with local FQHC's and other primary and specialty healthcare providers;
(8) Expand service-intensive PSH for close to 150 households and provide long-term subsidized housing and flexible, person-centered supportive services to individuals with disabilities who have intensive service needs and are experiencing homelessness. The PSH projects will help people obtain permanent housing, stabilize in housing and identify and achieve personal goals, and will augment CT BOS's ongoing efforts to open up more PSH resources (currently happening through Moving On vouchers).
(9) Monitor project implementation, evaluate performance and adjust policies, coordinated entry processes, training, and technical assistance to continuously improve efforts to reduce unsheltered homelessness.

This proposal will effectively address people's initial urgent needs and help them move quickly to the point where they can prioritize the creation of a housing plan. CT BOS has a coordinated strategy to identify people living unsheltered in each CAN and maintains this data in a shared environment. It also has shared CAN policies that clearly prioritize households living unsheltered. However, without enough staffing, people with the greatest needs often disengage because they see that we cannot really help them address their pressing concerns.

P-5.4.a,b&c: The initial priorities to be addressed would be driven by participants but are expected to include access to food/shelter, addressing urgent health care needs, obtaining birth certificates and identification; implementing harm reduction strategies, dealing with urgent legal matters, finding secure storage for belongings, getting a phone, connecting to health and behavioral health (MH and SU Treatment) care, and gaining access to public benefits such as Medicaid, SSI/SSDI and food stamps. Once initial critical needs are addressed, staff would build on the relationships formed, offering this specialized initial support to then work with the participant to develop a detailed housing plan. Staff from the services project would complete a "warm hand off" (as outlined in CTI) to more specialized housing staff for housing search and navigation support through the leasing and housing stabilization process. Outreach staff would continue to monitor linkages (per CTI) for an additional two or three months to assure that the linkages to treatment, healthcare and support services are working as planned. Most of the CT BOS providers are trained in CTI and participate in ongoing communities of practice to maintain fidelity to the model. CT BOS's combination of CTI service models, appropriate Outreach staffing, 147 units of new PSH, and new and deepened healthcare partnerships across the system will result in a significant reduction in unsheltered homelessness.

As noted, the CoC will use SO staff to ensure unsheltered homeless people have access to birth certificates and other forms of identification, housing navigation services and resources and supports like healthcare using the CTI model to connect to them to linkages and ensure they result in the desired outcomes. In the CANS, local healthcare providers are critical partners in accessing healthcare services and staff from local hospitals, clinics and FQHC's participate in CAN coordination meetings to ensure people gain access to these resources. CT DMHAS supports multiple efforts that strengthen linkages between the mental health, substance use and homeless systems: 1) Mobile Mental Health Crisis teams operated by Local Mental Health Authorities (LMHAs); 2) LMHAs participate in regular CAN meetings to ensure access to mental health and substance use treatment

services; 3) Care Coordination teams in each CAN facilitate connections between health and behavioral health care and the homeless system; and 4) Certified SOAR Specialists in each CAN assist with access to SSI/SSDI. Mobile Medication Assisted Treatment (MAT) vans are operated by four non-profit organizations around the state, with coverage ranging from 5-7 days a week to increase access to MAT for people living unsheltered with opioid use disorder. The vans are staffed by a nurse or physician and a peer recovery support counselor. Visitors to the vans can: receive a prescription for Suboxone; access a peer counselor, a Narcan overdose reversal kit and other harm reduction supplies—including syringe exchange and educational resources; and receive referral to a treatment center and transportation to a pharmacy. The service is free and does not require proof of insurance.

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

P-6.1: CT BOS has invested CoC Planning funds to launch and support a CoC workgroup of people with lived experiences of homelessness, called the "Consumer Leadership Involvement Project" (CLIP). Members of this workgroup are compensated at an hourly rate of $25. This lived-experience workgroup is routinely engaged by CT BOS to enrich the knowledge, approach, and policies of the CoC by providing input into CoC plans and strategies and reviewing CoC policies and governance documents regularly. CT BOS engaged the lived-experience workgroup to develop the plan contained in these pages—both to provide early input into the draft and to review and endorse the final plan.

CLIP employs a fellow to lead and support the project. The CLIP Fellow has lived experience of homelessness, used to live in homeless-dedicated Permanent Supportive Housing, and has a vast network of contacts throughout the state. This Fellow outreaches directly to people with lived experience through emails, flyers, announcements at CoC meetings, community meetings, visits to homeless programs, targeted outreach to homeless service providers, and outreach through the current CLIP members to tap into their networks through social media and word of mouth to recruit new CLIP members. CLIP provides members with mobile tablets and an internet plan, as well as training on using the tablets and online meeting platforms so that they can participate actively in videoconferences, enabling them to attend CoC meetings. CoC members have attended CLIP meetings to provide education around CoC policies and engage CLIP in providing input on key CoC decisions such as policies on coordinated entry, services, and housing.

P-6.2: CT BOS has also invested heavily over the past ten years in cultivating and expanding active representation of people with lived experiences of homelessness on the CoC Board, now with a total of 8 voting seats designated for people with lived experience (PLE), called "Community Representatives." These 8 PLE constitute at least 30% of the voting members for most votes, a proportion that results in great influence in shaping and codifying local policies and priorities. Two of the 8 positions are reserved for young adults who are members of the Youth Advisory Board (YAB). At least 5 of the 8 PLE have experienced unsheltered homelessness. With supports from CLIP, the working group described above, PLE have become increasingly integrated into the decision-making structure and have used their positions to wield influence in committees – for example, Board members with lived experience hold positions on the Scoring Committee and Grievance Committee, as well as participating in other workgroups dedicated to specific topics, programs, and policy areas. As community representatives, PLE vote on policies regarding funding priorities, project evaluation criteria, NOFO ranking and rating factors, and program and services standards. This year 50% of Grievance Committee participants were PLE. CLIP helps to ensure that PLE are supported as they learn new information, contribute their expertise, and change the quality and focus of the CoC Board discussions, providing necessary pushback to "the way things have been done" and bringing diverse age, race, ethnicity and LGBTQ+ perspectives into decision making. Further, the proportion of PLE holding voting seats ensures that their voices carry weight.

P-6.3: CT BOS, DOH, and DMHAS all include consumer interviews in their monitoring practices, as well as annual consumer surveys, the results of which are a scored factor for CT BOS annual renewal evaluations. Additionally, CT BOS, DOH, and DMHAS have communicated since 2010 that projects should incorporate people with lived experience and has been monitoring this to ensure that projects were following these

expectations. CT BOS, DOH, and DMHAS all included the following lived experience standards in their Street Outreach Monitoring Standards and CoC Program Monitoring Standards: (1) Recruiting, retaining and promoting people with lived experience of homelessness in staff and Board positions, and (2) Engaging people with lived experience of homelessness in meaningful opportunities to shape homeless services programs. Additionally, since 2016, the CoC has established bonus points in funding applications to create incentives for CoC members and CoC-funded agencies to provide professional development and employment opportunities for people with lived experience. This incentive has resulted in providers focusing on hiring people with lived experiences of homelessness, and particularly for Street Outreach, people who have lived unsheltered.

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

P-7.1 & 2: CT BOS identifies underserved communities and how they interact with the homeless system in three distinct ways:

Underserved Demographics (Point-In-Time Count)

Out of 247 unsheltered individuals enumerated in the 2022 Point-In-Time Count, the following demographic characteristics were represented in the unsheltered population, noting that (1) persons experiencing chronic homelessness and (2) persons of multiple races are overrepresented in the unsheltered population.

- Persons of Hispanic/Latino/a/x ethnicity: 21% of all unsheltered vs 25% of all sheltered
- Persons of Black or African American race: 34% of all unsheltered vs 37% of all sheltered
- Persons of multiple races: 7% of all unsheltered vs 4.3% of all sheltered
- Persons experiencing chronic homelessness: 17% of all unsheltered vs 5.4% of all sheltered
- Persons aged 18-24: 3.6% of all unsheltered vs 3.4% of all sheltered

Larger Trends in Unmet Needs (Statewide)

A 2022 study commissioned by the CT Department of Housing found that across the state, the homeless population – both long-term and first-time homeless – is growing older and increasingly medically fragile with more intensive healthcare needs, including those with disabilities. Soup kitchens have seen a significant uptick in certain subpopulations as well. Young adults, elderly and severally mentally ill individuals have been living on some soup kitchens' properties. The state PSH stock is large and caters well to people with disabilities; however, the severity of medical needs has increased and requires more investment and service provider focus.

Underserved Geographic Communities (Statewide)

In CT, as in the nation, communities are divided by race and social class, with lower-income households concentrated in urban areas. Further, people experiencing homelessness are more likely to be people of color. In CT, 38% of homeless persons are Black, while only making up only 12% of the general population. CT BOS providers, through their collaboration at the CAN level, have made sure that more resources are developed and maintained in the geographic areas where more people are unstably housed, balancing that with a need for geographically dispersed services. For instance, one service provider, Beth El Center, recognized that the New Haven CAN needed an anchor in Milford, where people travel from Bridgeport to New Haven to get services. They have been systematically creating a response system to serve people in the community where they live.

Under this NOFO, CT BOS applied for funding to address unmet needs in the rural areas of Litchfield County where safe and affordable housing is out of reach for thousands of households. Prior to the COVID-19 pandemic, more than 25% of Litchfield County's 17,000 renter households were identified as severely cost-burdened, paying 50% or more of income on rent. More than 45% of households are cost-burdened. As in many other geographies adjacent to metro New York, Litchfield County's 29 towns have seen a startling increase in both rents and the price of homes that is pushing essential workers and low-moderate income residents out of the region entirely. A 2021 statewide housing study found an affordable housing gap of 2322 low-income households.

P-7.3: Strategies to Serve Identified Populations and Communities

CT BOS uses a suite of strategies to ensure that diverse populations experiencing unsheltered AND sheltered homelessness are served adequately, including the following:

(1) **Racial Equity.** CT BOS ceased usage of the VI-SPDAT in light of numerous evidence-based concerns that the tool created unequal prioritization among races, specifically that the tool scored Black households lower than White households. CT BOS, CT Dept of Housing, and CT Dept of Mental Health and Addiction Services all include equity standards in their Street Outreach and CoC Program Monitoring Standards, including recruiting, retaining and promoting people who identify as BIPoC, Latinx and LGBTQIA+, and people from nations of origin and linguistic groups that are significantly represented in the relevant CAN in staff and Board positions; creating and maintaining an inclusive organizational culture that promotes equity; developing partnerships with local organizations that focus on work with marginalized populations; analyzing who gets access to your agency's homeless services programs and program outcomes by race/ethnicity/sexual orientation/gender identity to determine if access and/or outcomes are disparate; and planning and or implementation of steps to address any disparate access and/or outcomes.

(2) **Language Barriers**. CT BOS relies on 2-1-1 as the first point of access into the homeless system and a comprehensive referral resource to mainstream services across the state, including eviction prevention, job training, and other social services. 2-1-1 plays an important role in ensuring that people with Limited English Proficiency (LEP) or who speak only a non-English language can receive translation services in 110 languages, and their referral database is kept up-to-date with all available culturally appropriate services for people seeking services. CT BOS established an LEP sample policy for providers to adopt. CoC monitoring includes reviewing agency LEP policies and making associated recommendations.

(3) **LGBTQIA2S+ Equity**. While CT BOS's unsheltered numbers indicate no gender minority persons are living unsheltered, there are reasons why trans, non-binary, and queer people hide their transgender status or sexual orientation, and based on studies conducted across the country, this is likely a significant undercount. CT BOS trains all providers annually on the CT BOS LGBTQIA2S+ anti-discrimination policy, Equal Access Rule, and LGBTQIA2S+ cultural competencies, including appropriate pronoun and name usage, data confidentiality, physical accommodations, safety and privacy-related reasonable accommodations, assistance with legal name and gender marker changes, and connections to culturally appropriate community resources and healthcare providers.

(4) **Persons with Diverse Lived Experiences of Homelessness**. As described in P-6, CT BOS has invested in significant and diverse representation on its Board of persons of multiple races, genders, sexual orientations, transgender statuses and with lived experience of homelessness. This group actively shapes CT BOS policies and priorities, and conducts training and document reviews to strengthen the CoC's cultural competencies. Additionally, street outreach providers have hired people with lived experiences of unsheltered homelessness to conduct outreach and engagement. These approaches have improved the system's ability to tap into street networks, identify locations where encampments may be, and identify people who are newly unsheltered.

(5) **Persons experiencing Chronic Homelessness.** The proportion of people who are unsheltered and also experiencing chronic homelessness is 3x the proportion in shelter. CT BOS has drastically reduced the number of people experiencing chronic homelessness through targeted initiatives, including developing new PSH with intensive services. With funds from this NOFO, CT BOS will further their proven practice of expanding service-intensive PSH to end homelessness for the people least likely to resolve their homelessness.

(6) **Age Concerns**. Youth living unsheltered, especially those who have experienced longer periods of unsheltered homelessness, are at heightened risk of mortality, substance use, risky sexual behavior, and mental health disorders, compared to youth staying in shelters or transitional programs. LGBTQIA2S+ youth are twice as likely to be sex trafficked. Because of these risks, any young people identified as living unsheltered are immediately prioritized for shelter and housing, and each CAN employs youth-specific staff to help young people navigate the system and secure housing as quickly as possible.