Wake County CoC Membership Meeting

Monday, February 23rd

2:00 – 3:30 pm

Raleigh Housing Authority – Community Room

Don’t forget to sign in!

AGENDA

- Welcome & Agenda Review (5 min)
- CoC System and Lead Agency Updates (20 min)
- Lead Agency Annual Action Plan (15 min)
- CoC Plan to End Homelessness (40 min)
- HealthCare Highlight: Neighbor Health (10 min)

Lead Agency Updates

CoC Team Update

Welcome to our new CoC Department Business Officer,

Renee Moye!

Coordinated Entry (CE) Updates

Housing Matches

- Newbern Crossing matches- 5
- Women Center Permanent Supportive Housing- 2
- HOPWA Permanent Supportive Housing- 1
- Families Together Rapid Rehousing- 10

Veteran Workgroup

- Goal of workgroup is to improve coordinated entry for veterans
- Creating a space to collaborate outside of Case Conference.
- Improvement areas identified in first meeting were: Immediate vet connection to CE and ensure we're talking about vets who may be not be utilizing access sites. Next meeting Thursday 2/26

Coordinated Entry (CE) Updates

CE Queues and Direct Referrals

- Last stage of direct referrals being moved to our Community Queue
- Creation of Shelter, Street Outreach, Housing and Landlord Engagement Unit
    - Clients can access more opportunities utilizing the Community Queues & reduces administrative burden on our partners

Virtual Access

- Collaborating with community partners regional centers and libraries
- Working with IT exploring technology options

Upcoming CE Training

- Housing Problem Solving 3 Part Training Series (March 5th, 2026- virtual, March 23rd – in person)
- CE 101 (Feb 2026 – video on demand)
- Coming Soon – Veteran Training

HMIS Updates

System Performance Measures

- Be on the lookout for communication
- We need to update your grant information **by the end of this week**!
- Due to HUD March 4th

PIT/HIC

- Clean up will concentrate on beds and units on the night of the PIT.
- Make sure your data is entered/up to date for the night of the PIT, **January 22, 2026**.

HMIS Updates: Help Desk 101

HMIS@Wake.gov

- Help desk software coming soon
- Documentation Library in the works

This HMIS team is here to help!

- Never apologize for asking for help.
- Let us know your urgency/deadline.
- You want training? You got it (eventually).

Report requests

- Custom/advanced reports: give us two weeks.
- We would also rather help you run the report yourself!

More to come

- Library of materials (LMS)
- Agency Admin training

Annual Membership Renewal

- Per the Wake CoC Charter every Organizational and Individual Member of the Wake CoC must renew their membership annually.

- Separate forms for Organizational Members and Individual Members.

- All organizations and individual members who do not complete this form by **February 28th** will be reviewed by the Nominations Committee for active status.
  - The Nominations Committee may determine a member is no longer a voting member and will only be contacted about Wake CoC updates.
  - This will be conducted annually. Voting member status can be reinstated during the following calendar year's renewal process.

White Flag

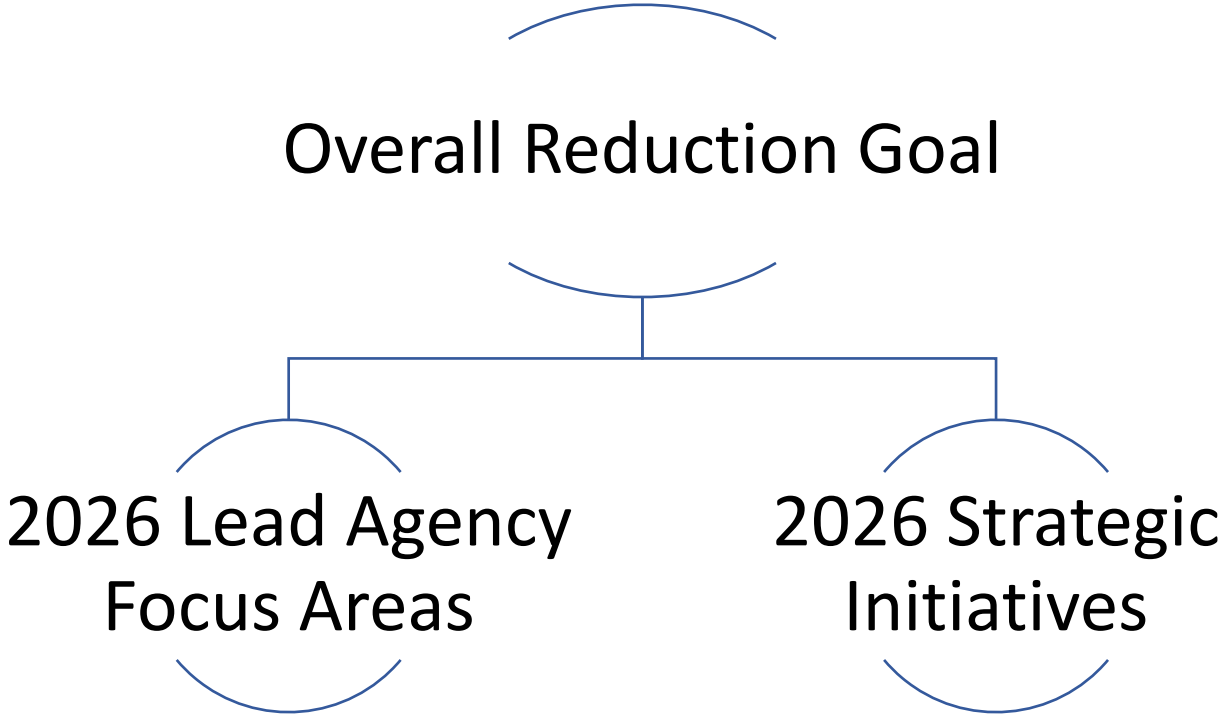
- 64 alert nights so far, out of 114 possible nights this season.
- Activated 24hr operations during storms 01/25-01/27 and 01/31– 02/02.
- Significant learnings for improved preparation and coordination, as well as insight on shelter needs.
  - Site changes and census management
  - Deployment of preventative resources (restroom trailers, generators, etc.)
  - Emergency plans for all shelters and temporary housing programs
- CoC HERC Committee will conduct full season debrief for public feedback and to inform planning for next season.

Special thanks to all who provided support with site operations, communications, logistics, staffing, meals, etc.!

Lead Agency Annual Action Plan

Reminder: Proposed Approach

- CoC is working to establish **2026 Strategic Initiatives.**
- Will evaluate multi-year strategic plan once system infrastructure is built out.
- Balance duties and deliverables in CoC MOU.
- Align with County Strategic Plan and City of Raleigh Affordable Housing Plan



Lead Agency Annual Action Plan

- **Purpose:**
  - Per enacting MOU, requirement to “develop strategic goals for Collaborative Applicant mandatory activities and include in an annual work plan”.

- **Background & Context**:
  - Tied to core services as Lead Agency, roles and responsibilities defined by HUD for CoCs and the enacting MOU for Wake County.
    - i.e. day-to-day work and operations of CoC.
  - Aligned with County departmental business plan.

Lead Agency Annual Action Plan

- **2026 Focus Areas**
  - **Data Management**: HMIS System Administration, Data Quality and Training.
  - **System Performance**: Expanding and formalizing performance monitoring framework, including ESG and CoC grantee monitoring.
  - **Access & Communications**: Cohesive communications strategy to improve awareness of available homeless services across community levels.

- **Detail provided in handout:** Lead Agency 2026 Annual Action Plan.

- **Recommended Action**: CoC Membership review for feedback and adoption.

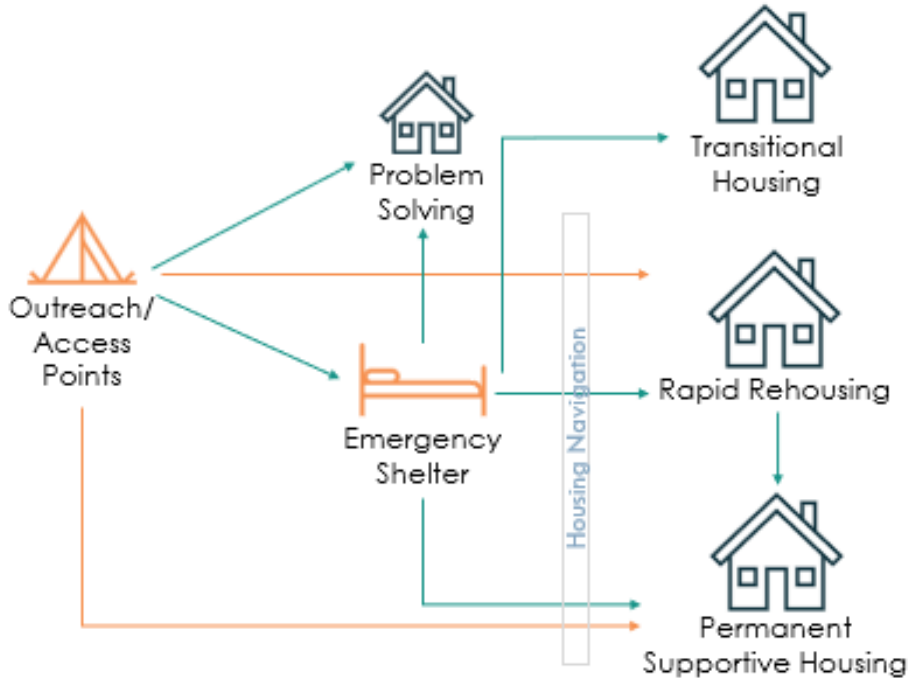
CoC Plan to End Homelessness

Reminder: Approach to Date

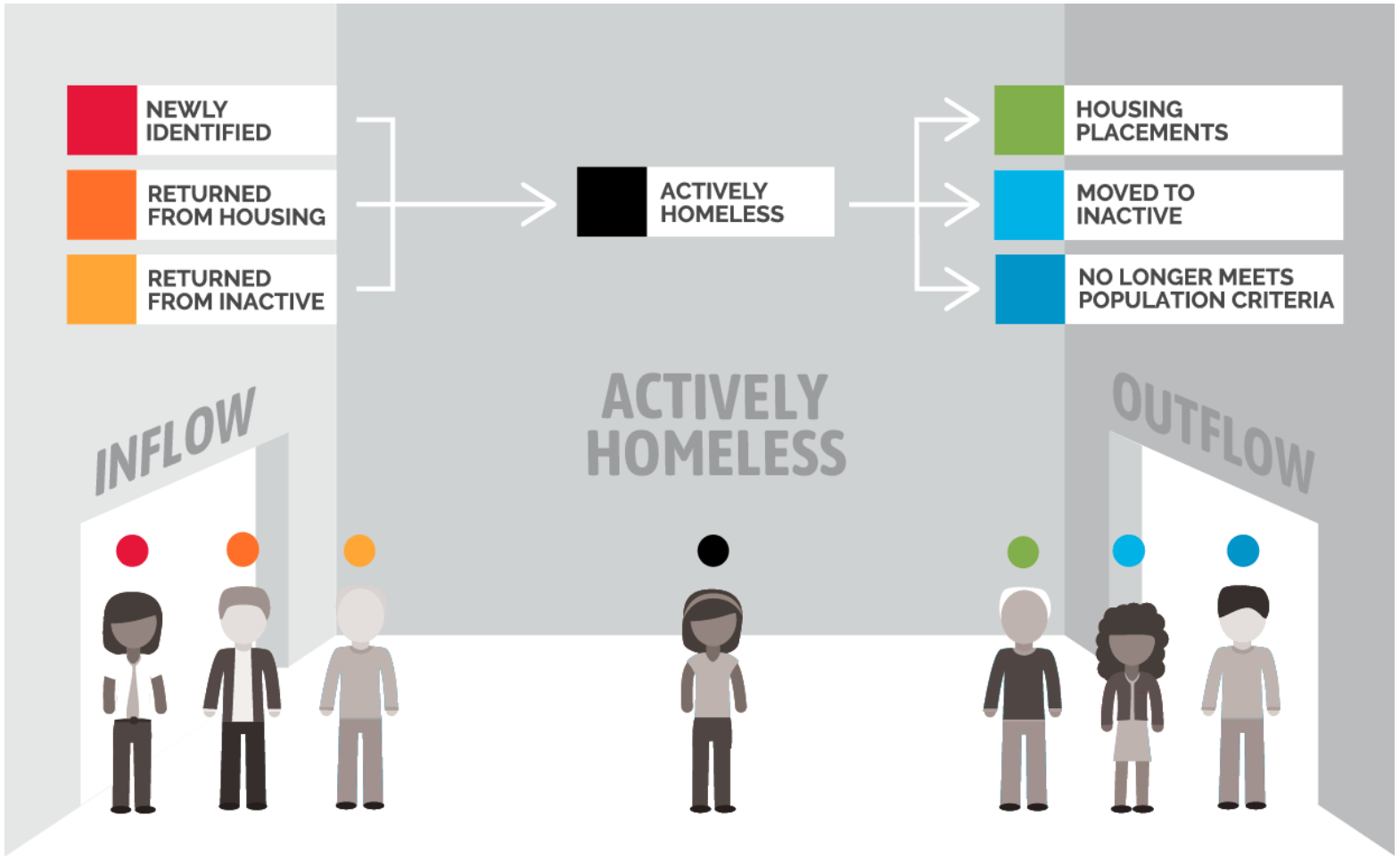
- CoC, City of Raleigh, Wake County (Housing + Behavioral Health) and Alliance Health participated in a dynamic system modeling session.
  - Led and informed by Clutch Consulting Group, known for marked reductions in unsheltered homelessness in other large cities (Dallas, New Orleans, Milwaukee).
- Developing resource, cost and implementation package to launch broader initiative to end homelessness.
- Areas of Focus:
  - Implement unsheltered homelessness strategy.
  - Scale diversion and rapid exit interventions.
  - Activate integrated care model.

System Modeling & Gaps Analysis

- Evaluating:
  - system demand - people entering homelessness
  - system capacity - inventory and exits to housing
- At this stage, making reasonable assumptions to identify optimal combination of projects and understand annualized costs



Defining End to Homelessness



- **Functional Zero:**
  - outflow > inflow

- **Rare**
- **Brief**
- **Non-Recurring**

https://community.solutions/quality-by-name-data/

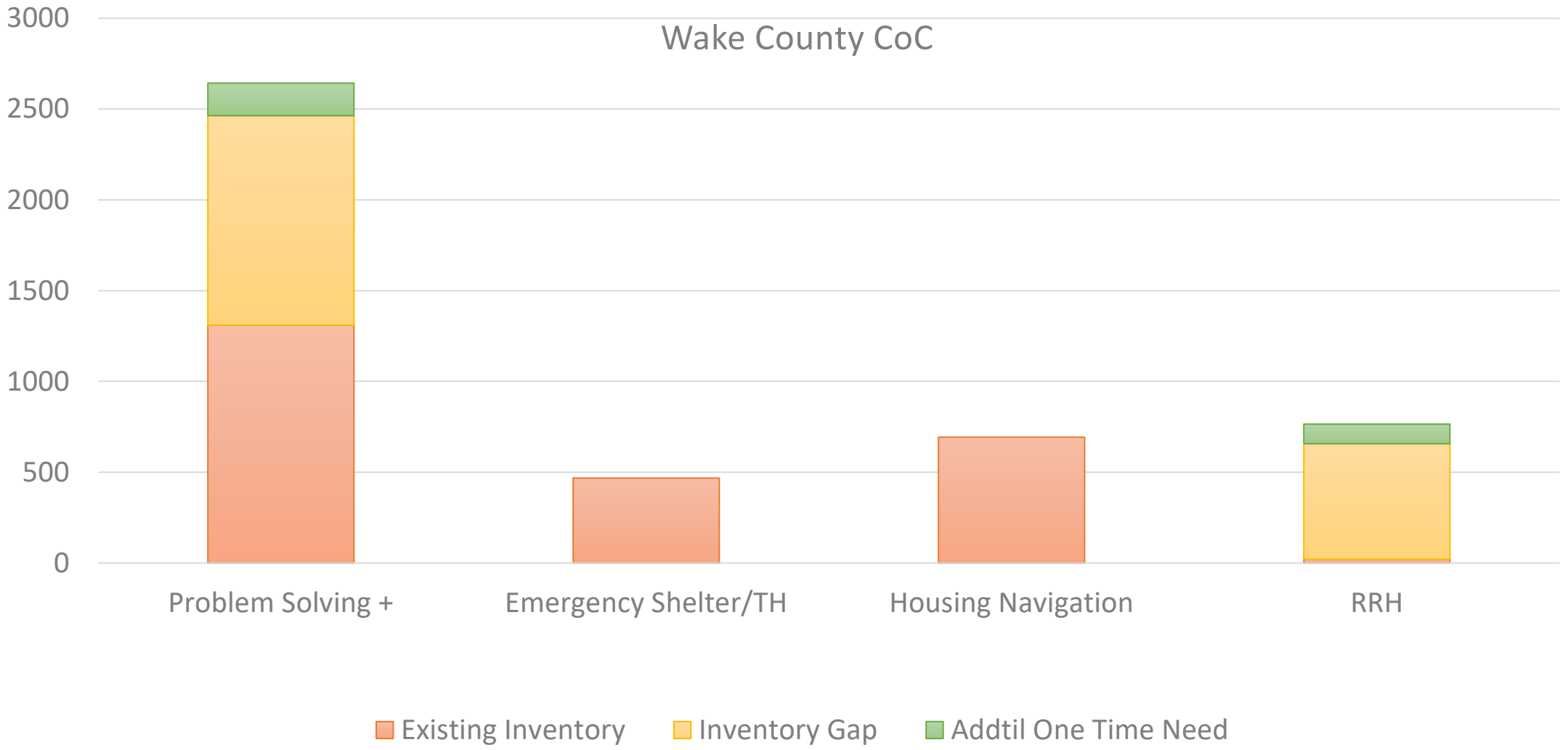
FFY2023-24 Wake CoC SPM Submission

Reflects **Performance IMPROVEMENT**

Reflects **Performance DECREASE**

Measure	Metric	Revised FY 2023	FY 2024	Change from Prior Year
Measure 1: Length of Time Persons Experience Homelessness	Average Days people spend in Shelter (ES-EE, ES-NbN, SH, TH)	58	56	**-2**
	Average Days people spend Experiencing Homelessness (ES-EE, ES-NbN, SH, TH and PH prior to "housing move-in")	485	524	**39**
Measure 2: Returns to Homelessness	Total percent of persons returning within 2 years	19.3%	18.9%	**-0.4%**
Measure 3: Number of Homeless Persons	Point-in-Time Count Total persons (sheltered and unsheltered)	992	992	**0**
	Annual Count Total persons (unduplicated count; ES, SH, and TH)	3,658	5,141	**1,483**
Measure 4: Income Growth for Persons in CoC Program-funded Projects	Adults with increased Total Income	47%	24%	**-23%**
Measure 5: First time Homelessness	Persons experiencing homelessness for the first time in the previous 24 months (accessing ES-EE, ES-NbN, SH, TH, or PH)	3,089	3,873	**784**
Measure 7: Successful Placement in or Retention of Permanent Housing	People with successful exits from Street Outreach	53%	69%	**16%**
	People with exits to permanent destinations from ES-EE, ES-NbN, SH, TH, RRH and PH (not moved into housing)	19%	15%	**-4%**
	People with successful Exits to or Retention of Permanent Housing (PSH and OPH, not RRH)	95%	97%	**2%**

System Capacity: Inventory Gap (Single Adults)



Unsheltered Homelessness Response

- Consistent engagement, triage and direct to housing encampment response.

Need/Demand	Annual Point in Time Count ~300 unsheltered individuals
Opportunity	Standardize unsheltered homeless response strategy (piloted through City of Raleigh) through **coordinated street outreach** and **dedicated housing**.

Immediate Interventions

- Equip shelters with the ability to quickly triage, divert new cases, and facilitate rapid exits from shelter to housing.

Need/Demand	Approximately 3,525 households are new or returning to homelessness each year • 92% only use shelter and stay average of 38 days • 36% of those who exit return within 6 months
Opportunity	Builds on Bridge 2 Home program offering **flexible financial assistance** and **creative problem-solving** to reduce long term homelessness.

Integrated Care

- Specialized support for complex care needs and targeted permanent housing for chronic and long-term homeless.

Need/Demand	Approximately 475 households chronic and long-term homeless ~ 60% of long-stayers indicate a disabling condition
Opportunity	• Informed by unsheltered pilot and permanent housing efforts for highly **medically vulnerable** (i.e. King's Ridge). • Leverage resources available under behavioral health, opioid settlement and other **system intersections** (medical respite, etc.)

Feedback Time!

- We have three questions for each of our three topics
  - Unsheltered Homeless Response
  - Immediate Interventions
  - Integrated Care
- Three feedback areas for each:
  - Must Haves (steps, features, etc.)
    - What should we **definitely** include in planning and/or implementation process?
    - What does this mean and/or look like to you?
  - Anticipated Challenges
    - What do you see as potential barriers?
    - Any special considerations to be cognizant of?
  - Partners to Include
    - Who do we need at the table? Be specific!

Timeframe & Next Steps

- Requires strategic investments in time-limited rent assistance/services, housing navigation, and diversion/rapid exit strategies.
  - CoC and Clutch updating cost and resource modeling.
  - CoC informed program design and implementation.

- This plan launches a phased approach with milestones under a **3-year surge investment.**
  - Mobilizes community, business, health care and faith-based partnerships while enhancing infrastructure of existing service providers.
  - Balanced against the cost of continuing to managing homelessness.

HealthCare Highlight: Neighbor Health

Why Health Care Access Matters for Individuals Experiencing Homelessness

Why it Matters

- Health and housing are deeply connected; without one, sustaining the other is extremely difficult.
- Access to care is not just a medical issue—it’s a stability and equity issue

Why it Matters

Increased Medical Vulnerability

- Higher rates of chronic disease, infections, and untreated injuries
- Environmental exposure accelerates health decline
- Minor conditions often become severe without early treatment

Why it Matters

Behavioral Health Needs

- Elevated rates of trauma, depression, anxiety, and substance use disorders
- Mental health care is often the entry point to stabilization
- Integrated care models improve outcomes significantly

Why it Matters

System-Level Impact

- Emergency departments become default care providers when primary care isn’t accessible
- Preventive care reduces hospitalizations and long-term costs
- Community clinics and outreach programs improve efficiency and outcomes

Why it Matters

Health as a Foundation for Stability

- Treatment enables individuals to pursue employment and housing opportunities
- Better health increases engagement with support programs
- Access to care restores dignity, trust, and hope

Services at NHC

- Adult Health
- Children's Health
- Women’s Health
- Prenatal Care
- Behavioral Health
- Coordination Services
- Low cost and free drugs

Patients

- Uninsured
- Underinsured
- Medicare
- Medicaid
- Same day walk-in

Contact

Clinic Location
2605 Blue Ridge Rd, Raleigh

www.neighborhealthcenter.org

Daniel Lipparelli, CEO
dlipparelli@neighborhealthcenter.org

Adjourn

Next CoC Membership Meeting:
- March 23, 2026 from 2 - 3:30 PM
- Raleigh Housing Authority (Community Room)

Tentative Agenda
- System Performance Measures
- Strategic Planning

CoC Coordination or for more info: Info@wakenc507.org