C.A.R.E.S

C: Coordination, Collaboration, Community-Building & Civility

A: All neighbors are known

R: Residence, A place to call home

E: Education (prevention & early intervention)

S: Supports (SDOH--education, financial capability, workforce development, integrated health [i.e. behavioral & physical], social capital, transportation, policy innovation, etc.)

C: Coordination, Collaboration, Community-building & Civility

Goal: Strengthen existing partnerships and service provider capacity & deepen community connections among neighbors for the purpose of both meeting needs and creating opportunity for our neighbors who are homeless, and, neighbors & businesses who are impacted by the issue of homelessness

Why: The homelessness needs assessment found the existing service delivery system is meeting the needs of individuals who are homeless and respond effectively to a structured program. It is essential to not only maintain the support of the existing system and providers but to also strengthen its capacity to ensure the sustainability of this effective response in meeting the needs and opportunities of our neighbors who are homeless.

The homelessness needs assessment also uncovered a critical gap—responding to the needs of individuals who homeless, are experiencing substance use or mental health issues, and, may also be intersecting the criminal justice system. Approximately eighty percent of the participants in the study of people who are homeless indicated they had never encountered an outreach worker when they were unsheltered. Further, nearly fifty-two percent of participants had experienced homelessness before—with nearly fifty-one percent of the participants experiencing homelessness for a year or more. The amount of time spent in homelessness for the past three years equaled twelve months or more for seventy-one percent of participants. Although the disability status of the study participants was not documented, these rates of long-term homelessness and repeated episodes of homelessness in Waynesville likely suggest higher rates of chronic homelessness in the area, as well as a need for increased outreach and supportive housing programs. Recognizing that individuals may not seek services on their own or otherwise become known to providers, the United States Interagency Council on Homelessness considers street outreach as a best practice in ending homelessness and connecting people to stable housing and other supportive services (USICH, 2019). The USICH (2019) also identifies effective practices for street outreach, including: systematic, coordinated and comprehensive outreach; housing-focused outreach; person-centered, trauma-informed and culturally responsive outreach; and, emphasizing safety and reducing harm.[1]

[1] ??????? ???d????? ?r? ????????? ??? ??????? ??r? ???? ??????? ???? ??r?????

In addition to evidence that suggests chronic homelessness, our neighbors who are homeless also report being victims of crime at a higher rate (thirty-six percent) than the general population. Further, forty-eight percent of participants experienced anywhere from one to more than seven episodes of incarceration. This data indicates two distinct sub-populations of people who are homeless in our community—i.e. those who are encountering our justice system and requiring its resources and those who are not. To assess the level of potential impact of criminal involvement and behavior, participants who were incarcerated in the last 12 months were asked to indicate the highest type of crime for which they were convicted. Sixty-two percent of participants who had been incarcerated in the last 12 months indicated they were convicted of a felony. This data indicates street outreach as well as more intentional and focused coordination of care may prevent or reduce involvement with the criminal justice system and improve individual well-being for people who are homeless and community quality of life for all residents of Waynesville.

Due to the intersecting and complex causes of homelessness, effective community efforts often require the intentional collaboration and coordination of various stakeholders—including people who are homeless, housing providers, behavioral health providers, physical health care providers, law enforcement, probation, faith leaders, education and workforce development, and other supportive services. It should be acknowledged that collaborative efforts already exist in our community—and it also should be noted that these efforts would benefit from additional resources and supports. Noting the particular resource constraints in rural communities, HUD (2010) identifies a community "connector" or "champion" as a critical success factor in high-performing rural areas. The recommended CARES Director should fulfill this critical role in strengthening cross-agency (including business, government, and not-for-profit providers) collaborations, developing a shared vision to address local needs and opportunities, bridge-building and inside and outside homeless delivery system, and, cultivating creative and innovative responses to community needs and opportunities.

Community connections often serve as protective and preventive factors against homelessness (Kelly, 2020). Activities that bring community members together provide critical community-building for relationships to be developed among community members, information about resources and opportunities to be shared, and civil discussions to occur.

Action Steps	Year				
	1	2	3	4	5
Coordination & Collaboration					
TOW appoints hiring committee for CARES Director	•				
TOW hires Community CARES Director	•				
Community CARES Director establishes a care coordination team of community-based providers	•				
Community CARES Director, on monthly basis, convenes CARES coordination team to connect PWH to service providers/services	•	•	•	•	•
Community CARES Director engages with & connects PWH to services, engage with neighbors & businesses and respond to issues associated with homelessness	•	•	•	•	•
Community CARES Director hosts monthly meetings with neighbors and businesses impacted by homelessness, communicate needs & opportunities to appropriate officials, implement actions	•	•	•	•	•
CARES Director tracks aggregate data & outcomes for success measures & reports quarterly at BoA meetings	•	•	•	•	•
Community-building & Civility					
Annual Community Picnic (i.e. public-private partnership event)	•	•	•	•	•
Establish and Implement Community-Building & Engagement Mini-Grants	•	•	•	•	•
Identify Facilitator & Convene Community Study Circle(s)			•	•	•

A: All Neighbors are Known By Name

Goal: By using an evidence-informed and baseline "by-name-list," cultivate community, increase prevention of homelessness, and/or expedite connecting neighbors to services and opportunities

Why: As noted above, the homelessness needs assessment documented eighty percent of the participants in the study of people who are homeless had never encountered an outreach worker when they were unsheltered. If our neighbors who are homeless are not encountering providers, then it is likely they are not accessing services as expeditiously as possible to return them to stable housing. Further, the inaccuracies and inefficiencies of point-in-time counts have long been documented (Trawver, Oby, Kominkiewicz, Kominkiewicz, & Whittington, 2019). Overseen by a Town of Waynesville CARES Director who can maintain confidentiality and privacy of sensitive data, a list of our neighbors who are homeless will help facilitate coordination of services as well as document a more accurate census of individuals who are homeless.

Action Steps	Year				
	1	2	3	4	5
All Neighbors are Known By Name					
CARES Coordination Team establishes shared "by-name-list"	•				
CARES Coordination Team meets every month to review "by-name-list" & connects PWH to services	•	•	•	•	•
CARES Director, in partnership with coordination team, tracks aggregate data & outcomes for success measures & reports quarterly at BoA meetings	•	•	•	•	•

R: Residence, A Place to Call Home

Goal: Strengthen individual well-being and community quality of life by rapidly connecting individuals at-risk of homelessness to housing, and supporting efforts to expand & develop low-cost affordable housing in safe neighborhoods including rental units and home ownership programs.

Why: As documented in the socioeconomic data for Waynesville, there are significant structural and systemic issues that make it challenging to use existing housing supports and services. For example, our community has access to Rapid Rehousing supports to quickly secure stable housing for people who are homeless but the supply of affordable, full-time rentals is limited. "Could not afford rent" was identified as one of the top three causes of homelessness among study participants who are homeless. Further, nearly thirty-eight percent of study participants indicated they had not accessed any housing services in Waynesville. Yet almost 100 percent of study participants indicated they would move into safe, affordable housing if it were available. Seventy-five percent of study participants shared they could afford $500 or less in rent/housing cost per month. According to the U.S. Census Bureau, the 2019 median monthly rent in Waynesville was $810 and the 2019 median monthly mortgage was $1,152 (2019). In 2019, the rental vacancy rate was approximately five percent. Approximately, fifty percent of Waynesville's renters are estimated to be housing cost-burdened or, paying more than thirty percent of their income for rent (HUD, 2020). It is likely these cost-burdens and medians have increased during the pandemic as well as in the aftermath of the floods in neighboring communities that have furthered strained the supply of housing in our community.

The 2020 point-in-time count indicated a total of 130 people who were homeless—100 people who were sheltered, and 30 who were unsheltered. Given the limitations with the point-in-time count methodology, it is likely these numbers represent an undercount of Waynesville's population that is homeless. With more intentional and focused outreach and coordination of care combined with addressing systemic and structural housing issues—it is possible to more effectively use existing supports and services to connect our neighbors who are homeless to stable housing.

Action Steps	Year				
	1	2	3	4	5
Strengthen and Expand Capacity of Current System					
Town of Waynesville's financial support increased to service providers that focus efforts on existing need by creating a clear application process	•	•	•	•	•
Community CARES Director either provides or secures capacity-building and team-building professional development for CARES coordination team	•	•			
Community CARES Director facilitates expansion of provider participation and PWH access to Coordinated Entry, Rapid Rehousing, LIHTC, Section 8 Vouchers, PSH units	•	•	•		
Community CARES Director evaluates capacity-building, team-building, & access of Coordinated Entry, Rapid Rehousing, LIHTC, Section 8 Vouchers, PSH units			•		•
TOW increase affordable housing units: Rental & Homeownership Opportunities	•	•	•	•	•
Community CARES Director facilitates expansion of partnerships with landlords	•	•			
Community CARES Director tracks aggregate data & outcomes for success measures & reports quarterly at BoA meetings	•	•	•	•	•
TOW assesses progress, makes modifications as needed; after year 3 and year 5 determines if model is working or additional shelter is needed	•	•	•	•	•

E: Education

Goal: Expand prevention and early intervention education strategies that prevent or mitigate homelessness

Why: Through its work groups, the Task Force documented efforts by our local schools and community agencies to teach positive coping skills to youth. It is recommended the CARES Director and coordination team work in collaboration to support these existing activities that prevent homelessness and promote individual well-being. Further, through many of the Task Force's work groups, it was learned the community had an interest in learning more about homelessness, housing, and community-building activities. It was also suggested that an annual housing fair would be helpful in connecting Waynesville's neighbors to existing housing services and opportunities.

Action Steps	Year				
	1	2	3	4	5
Individual-level education: Community CARES Director works with community agencies, schools, partners to support teaching positive coping skills and building resiliency among youth	•	•	•	•	•
Community-level education: Community CARES Director provides or coordinates quarterly and annual reports on homelessness issues at BoA meetings	•	•	•	•	•
Community-level education: Community CARES Director coordinates quarterly speaker series on issues related to homelessness, housing, & community building		•			
Community-level education: Community CARES Director coordinates annual housing fair	•	•	•	•	•
Community-level education: Community CARES Director coordinates poverty simulation hosted every other year		•		•	

S: Supports

Goal: Identify community assets and build network capacity to connect people who are homeless, other neighbors, and businesses to services and opportunities

Why: In order to maintain stable housing, it is often helpful to connect individuals to supportive services which may include behavioral health, physical health, dental care, education, workforce development, peer support, transportation, pro-social and affordable recreation, basic services, spiritual enrichment, and governmental services. The homeless needs assessment documented that many individuals who are homeless are not currently accessing several services that may support their efforts to remain stably housed. For example, study participants noted they had not accessed the following services at notable non-participation rates: housing services (37.5%), mental health (36.4%), physical health (40.7%), substance use (50.9%), and transportation (40.7%). When asked what services they found helpful, the highest rated service was food assistance. Seventy-one percent rated food assistance services as either mostly or very helpful. Among the least helpful services, eighteen percent of participants did not find either mental health services nor housing services helpful. It is also worth noting that thirty-five percent of participants applied for and were denied Medicaid services in the last two years.

Ninety-one percent of participants have not accessed dental care in the last year. Most participants (55.4%) have also not accessed behavioral health services in the last 12 months. Approximately thirty-six percent of participants have not accessed a health care provider in the last 12 months. Yet forty percent of participants reported having both a current physical and mental health condition. Conversely, fifty-seven percent of participants have visited the emergency department 1-3 times in the last 12 months.

Action Steps	Year				
	1	2	3	4	5
Community CARES Director builds network capacity between/among housing and other providers/resources: Behavioral health, physical health, dental care, education, workforce development, peer support, transportation, pro-social & affordable recreation, basic services, spiritual, governmental services, etc.	•	•	•	•	•
Community CARES Director coordinates the following mental health action items: • Mental health first aid training for community • Host panel of Mental health providers • Explore empowering and participatory programs for people who are homeless (i.e. programs planned/facilitated by PWH—for example, support groups, street outreach, arts/cultural enrichment, etc.) • Explore pilot of public-facing pro bono clinic staffed by experienced clinicians • Explore feasibility of implementing of a Community Response Team	•	•	•	•	•
Community CARES Director and Care Coordination Team uses network capacity (& possibly NCCare360) to connect PWH to appropriate service and support mix	•	•	•	•	•
Community CARES Director identifies & maps support services assets for both people who are homeless and businesses	•		•		•
Community CARES Director leads effort to explore Policy Innovation in support of CARES Action Plan: • TOW affordable housing set-asides (inclusive zoning) • Landlord incentives for affordable set-asides, Rapid Rehousing and/or Voucher participation	•	•	•	•	•

• Child Development Accounts—particularly for youth who are under 5 & identified as living in poverty • Map and identify vacant land/property that may be used for housing development—including affordable units • Access to mental/behavioral health services (including support of Medicaid expansion) • Response to the pre-trial release program—document summons, citations; • Strengthen communication & partnership between LEOs and magistrates; • Monitoring and supports for individuals on pre-trial release (i.e. check-ins, connections with providers) • Support recovery court in Haywood County					