Reconnect – Rebuild – Rethink

An emergent continuum of care to ensure housing stabilization in Louisville, KY
THE TASK AT HAND

A city where every person facing a crisis that challenges basic human flourishing has someone they can turn to for nonjudgmental support, accompaniment to abundant resources, social (re)connection and compassionate advocacy.

“The fruit of such compassionate curiosity is that fear gets transformed into bravery.”
THE CHALLENGE

With an increased sense of scarcity, social services are forced to significantly limit their accessibility and support while maintaining record numbers as ‘outcomes’

• Expected to implement corporate solutions for social problems
• Decreasing funds paired with increasingly complex needs (leads to scarcity mindset/competition)
• Organizational trauma leads to reacting to urgent ‘fires’ instead of creating slow, healing environments
• Limited support and accompaniment for people who fall outside of program requirements
LESSONS LEARNED

With extensive data and shared experience from an influx of financial assistance from federal pandemic relief, the collaborative efforts required from the past three years continue to work together in efforts “not to go back to the way things were”

• Without continued care addressing all basic needs, crises reemerge
• There’s a shortage of case managers
• Our ecosystem of care has significant service gaps and barriers
• Burn out is real and we need care for our care givers
THE OPPORTUNITY:
SYSTEM CHANGE IS BUILT ON HUMAN CONNECTION

• Readiness to listen to direct service providers
• Interest from donors to try a new approach
• An increasingly involved healthcare system
• Extensive networks of real people who want to help their neighbors
• Better tools to organize and communicate
OUR (HOPEFUL) SOLUTION

Reconnect People
Centralized intake & triage

Rebuild Care Systems
CST team coordination & care

Rethink Social Services
Emergent & Visionary Alternatives

(Vision Realized!)
RECONNECT: CENTRALIZED INTAKE

Crisis
What's happened to you?
What is changing?
What do you want to happen?

Basic Needs
housing
transportation
digital access
utilities
employment
food
banking
social support
health care

Descriptors
young adult or children, seniors, foster care, LGBTQ+, pregnant, chronic illness, disability, immigrant/refugee, domestic violence, veteran

Prioritizing steps and goals
Assessing layered needs
Connecting with intention
While considering:
- client goals, eligibility
- requirements, barriers, and capacity

Building journey maps that include:
- practitioners, tools, tips/tricks, and resources

For things like: stable housing, long-term employment, health care, resource navigation, counseling, and more

Creating multi-layered care plans and communicating next steps with clients in a timeframe that feels right and makes sense
REBUILD:
COMPENSATED, SUPPORTED, & CONNECTED CARE TEAMS

Rule-benders: Creating solutions
Goal Navigators: Experts in Ecosystems
Practitioners: Providing a specific service
Community ‘Doulas’: Accompaniers
Clients: Change agents
WHAT IT HOPEFULLY FEELS LIKE

A group of people who care what happen to you so much they rally around you as often as it takes
RETHINK: EMERGENT AND VISIONARY ALTERNATIVES TO SERVICE GAPS AND BARRIERS

1. Articulate prioritized service gaps and barriers our low-income population face when trying to cover their basic needs

2. Implementation of immediate/micro problem solving leading to long-term/macro problem solving through innovative collaboration

3. Through relationship and discussion, we'll lift up the visionary alternatives with accessible and courageous next steps with ways to plug in and take action that feels good and accountability that's helpful and non-accusatory
1. Unconditional positive regard is where we begin

2. We follow the front line & act collectively

3. We learn through deep empathy & radical curiosity

4. Trauma informs us, human connection heals us

“Systems won't change until people do – and people change when they're cherished.”
GET DOWN TO THE BRASS TACKS!

1) Centralized Intake on stopmyeviction.org for anyone struggling to meet their basic needs

2) NN Care Coordinator reads the intake and, based on clients goals and needs, creates a care plan to include 1-5+ journey maps

3) Client receives text in 24 hours with next steps – typically a secondary questionnaire asking for more details that would determine a helpful referral

4) Referral is made and client understands their own next steps after confirming their comfort, ability, and interest

5) Goal Navigators follow up 1-2 weeks after to ask how it went and if anything has changed with the option to start over, help with the new barrier, etc.

6) If systemic barriers persist, we engage with community partners to help both the individual client while collaborating around visionary alternatives