

## Reconnect – Rebuild – Rethink

An emergent continuum of care to ensure housing stabilization in Louis ville, 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

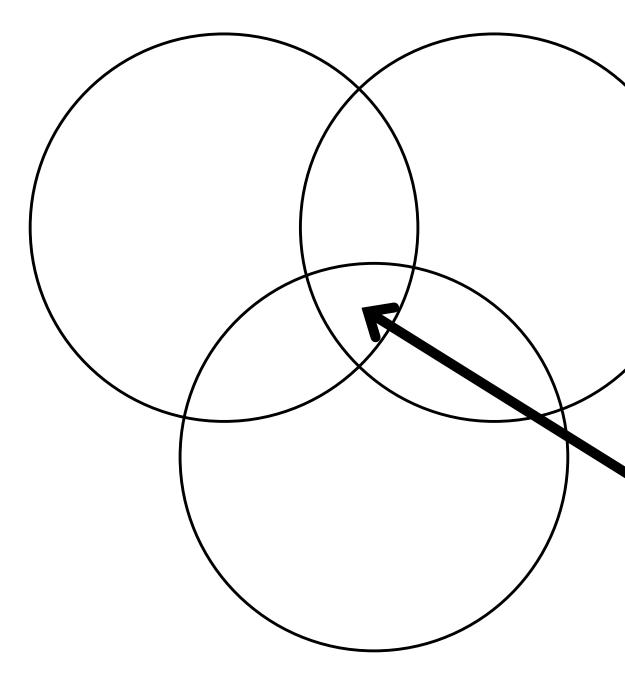
## THE OPPORTUNITY: SYSTEM CHANGE IS BUILT ON HUMAN CONNECTION

- 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

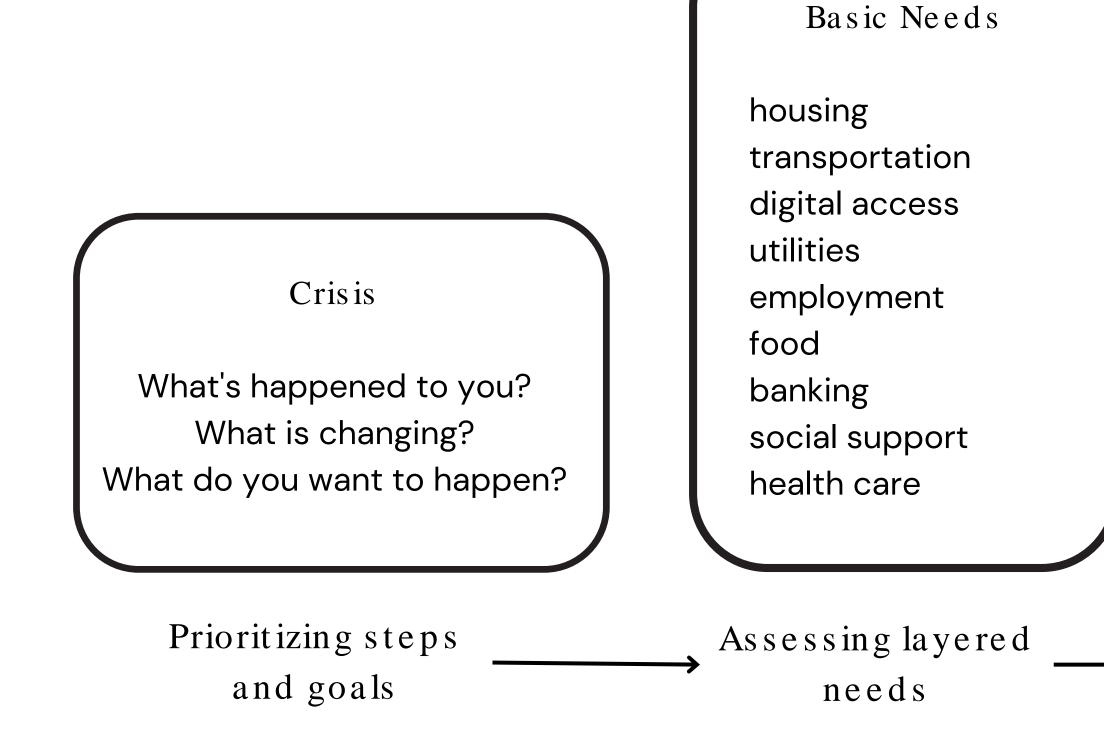


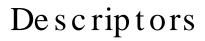
## Rethink Social Services Emergent & Visionary Alternative s

## Rebuild Care Systems CST team coordination & care



# RECONNECT: CENTRALIZED INTAKE





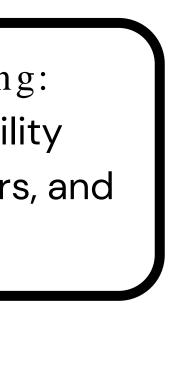
young adult or children, seniors, foster care, LGBTQ+, pregnant, chronic illness, disability, immigrant/refugee, domestic violence, veteran

Connecting with intention

## **RECONNECT: TRIAGE**

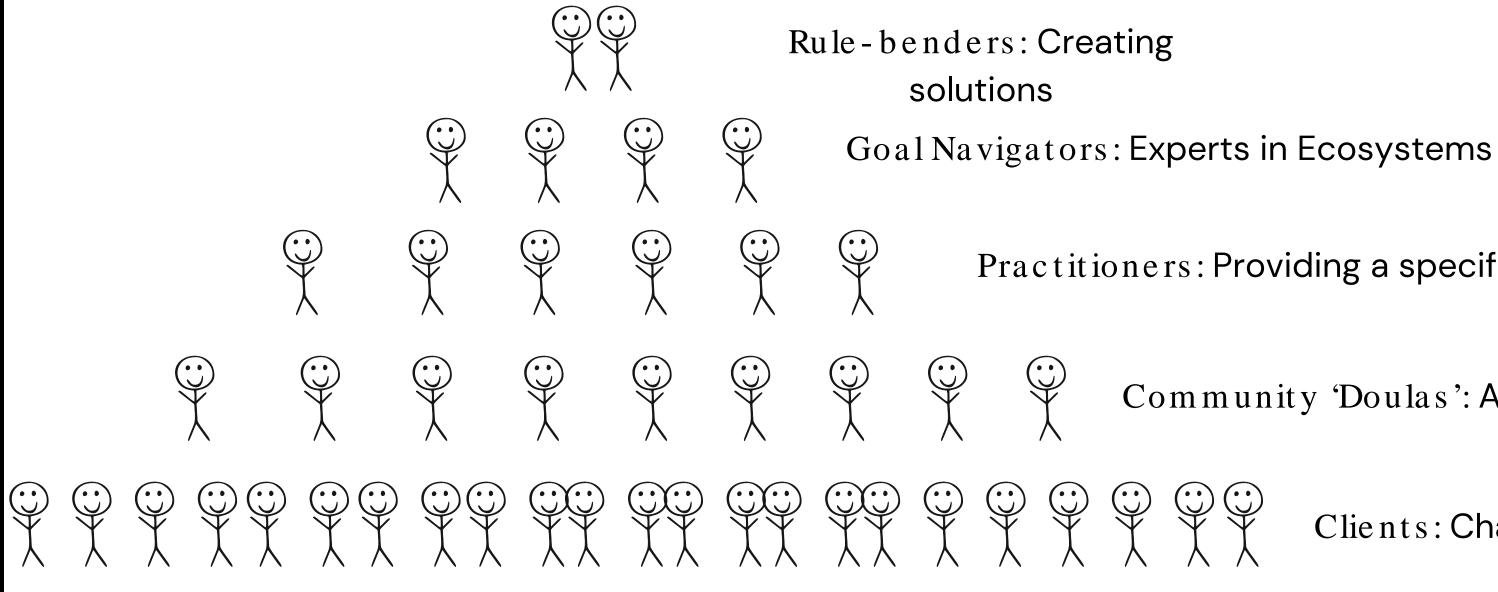
Building journey maps that include: practitioners, tools, tips/tricks, and resources While considering: client goals, eligibility requirements, barriers, and capacity

Creating multi-layered care plans and communicating next steps with clients in a timeframe that feels right and makes sense



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

## REBU COMPENSATED, SUPPORTED, & CONNECTED CARE TEAMS

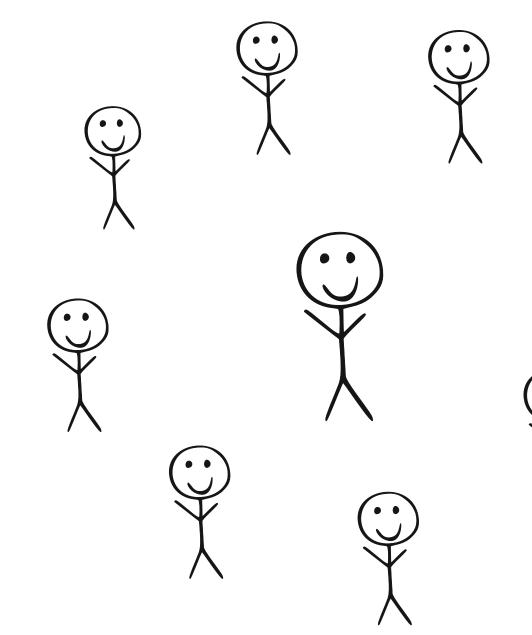


Practitioners: Providing a specific service

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



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



Implementation of immediate/micro problem solving leading to longterm/macro problem solving through innovative collaboration



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

## HOW MATTERS

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

cherished."

# "Systems won't change until people do – and people change when they're

## 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