HOMELESS SERVICES IMPACT REPORT

City Net Case Manager surveys homeless neighbor during a 2020 census.

HOMELESS SERVICES

- Weekly Collaborative Street Outreach
- Case Management
- Reunifications
- Housing Navigation
- Law Enforcement Partnership
- Census Coordination & Data Analytics
- Community and Medical Partnerships

CITY NET IMPACT STORY: JOE

Joe is a senior citizen who had been experiencing homelessness for 16 years. He cycled in and out of the local shelter programs, but primarily slept on the streets and could be found panhandling at many of the off-ramps around town. Joe suffers from a painful physical disability and struggles with substances in an attempt to manage the pain. The Santa Barbara Police Department referred to the City of Santa Barbara Connect Home project due to his high utilization of the emergency room and police services, averaging about 6 emergency room visits per month. City Net Case Managers met with Joe and began to build trust and rapport with him. He was very discouraged and was struggling to cope with the loneliness and challenges of living unsheltered. He had given up hope on housing because, as he said, “you can’t teach an old dog new tricks.”

JOE'S JOURNEY TOWARDS HOUSING

STREET OUTREACH - 14 INTERACTIONS

4-8-19

City Net Case Manager is introduced to Joe by Santa Barbara Police Department. He expressed distrust of "service providers," and was wary of police presence.

CASE MANAGEMENT - 94 HOURS

4-12-19 to 7-22-19

After 14 more visits, City Net staff earned Joe's trust and he was interested in working with us to get connected to housing. Our case manager began the intake process, including:

- Completion of City Net intake forms and waivers
- Assistance in getting Joe “document-ready” for housing:
  - Homeless Management Information System record entry
  - Confirmation of valid ID card, Social Security card and birth certificate
  - Referral to medical services for Joe’s medical needs, including referring him to Doctor Without Walls and Cottage Health Community Nurse for urgent medical care in the field and connecting him to a new primary care physician

7-23-19

Joe's Case Manager began the process of submitting the necessary paperwork on his behalf so he can access housing resources within the County’s Continuum of Care.

7-30-19, 8-16-19, 9-3-19

Cottage Health Community Outreach Team, including a registered nurse and licensed clinical social worker, provided ongoing support for medical, mental health, and basic needs. City Net transported Joe to his primary care and wound care appointments on multiple occasions.

10-11-19

Case Managers coordinated with hospital Social Workers on his discharge plan.

11-22-19
A care schedule was established in which Cottage Health community nurse and social worker and City Net staff would meet Joe in the field twice per week to perform wound care.

1-28-20
The Case Manager initiated a conversation about a local senior living housing unit that provides wrap-around services, including meals, transportation and more.

2-28-20
Joe completed all necessary steps for housing. Despite struggling with his disability and poor health, Joe persevered and City Net Case Managers transported him to his Santa Barbara Housing Authority appointment to get matched to a unit. Joe was approved and was scheduled to move into the next available unit on May 20, 2020.

3-31-20
City Net bridged Joe in a motel to protect him from possible medical complications due to COVID-19. Case Managers and Cottage Health community nurses visited him daily to provide food and assess his needs. This allowed City Net to learn about potential difficulties he might face when transitioning into housing after 16 years of homelessness, and provide him with assistance as needed.

5-20-20
On Joe's move-in day, he was anxious about moving into permanent housing. Case Managers met with him for two hours to encourage him to take this next step in his journey. He agreed to "try it out" and move in.

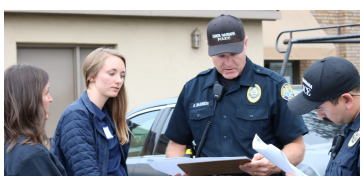
5-21-20
Joe was happy with his decision and enjoyed his new place. He signed up to receive In-Home Supportive Services as he continued to transition into this new stable environment.

HOUSING STABILIZATION SERVICES - 61 HOURS

5-22-20 to 10-15-20
Case Managers coached and assisted Joe as he adjusted to having a place of his own, encouraging him to adhere to rules and guidelines of the local senior living program, including interacting with other residents appropriately, taking advantage of onsite transportation, sticking to curfew, keeping his new space clean, maintaining personal hygiene, and more.

10-19-20 to Present
Following a long-overdue cataract surgery, Joe's vision improved significantly. He was motivated to continue to take better care of himself and reach new personal milestones, including physical therapy attendance, connection to Veterans Affairs, and improved personal hygiene.

13 Months	14 Agencies	168+ Interactions	83.3% Decrease	99.8% Decrease
Length of time from first outreach contact to permanent housing placement	Partners that collaborated to help Joe on his journey to permanent housing	Number of times City Net Case Managers met with Joe to work on his health and housing plans	Average emergency room visits per month decreased from 6 to 1 after being housed	Number of contacts with police decreased from 951 since 2014 to 2 after being housed



City Net

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