PROGRAM INFORMATION:

Program Title:	Turning Point - Stasis Center	**Provider:**	Turning Point of Central California, Inc.
Program Description:	Permanent Supportive Housing	**MHP Work Plan:**	Choose an item. Choose an item. Choose an item.
Age Group Served 1:	ADULT	**Dates Of Operation:**	2005- current
Age Group Served 2:	Choose an item.	**Reporting Period:**	**July 1, 2022 – June 30, 2023**
Funding Source 1:	Realignment	**Funding Source 3:**	Choose an item.
Funding Source 2:	Other, please specify below	**Other Funding:**	HUD FUNDING

FISCAL INFORMATION:

Program Budget Amount: $112,021 **Program Actual Amount:** **$112,021**

Number of Unique Clients Served During Time Period: 35

Number of Services Rendered During Time Period: 7,863 Nights of Shelter and daily supportive services.

Actual Cost Per Client: $3200.60

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	Other, please specify below
Contract Term:	2/1/2016 – 1/31/2023	**For Other:**	Permanent Supportive Housing
		Renewal Date:	2/1/2021

Level of Care Information Age 18 & Over: Choose an item.

Level of Care Information Age 0- 17: Choose an item.

TARGET POPULATION INFORMATION:

Target Population: Stasis Center targets the chronically homeless and individuals diagnosed with a severe mental illness from the ages of 18 and older. Most residents come through the Coordinated Entry System and MAAP who asseses them. The remaining residents were/are referred through Fresno County or other agencies. Individuals are document ready which will include assessment for diagnosis through the County. Individuals will be referred to County services or FSP services if they are not already accessing services through Fresno County or another provider. The program is geared to assist adults to overcome barriers that hinder their

ability to be self sufficient and independent. More important, Stasis assists with supportive services that help the individual reach personal goals such as; employment, education, socialization, budgeting and all life skills. Services include appropriate mental health referrals, referrals to doctors, service plans, one on one meetings with Resident Advisor, social activities, weekly home visits, medication monitoring, crisis intervention and all other referrals as needed. All service plans are used to assist all individuals in setting short and long term goals. The client will meet with the Resident Advisor monthly to go over new goals, reached goals and barriers. Staff diligently works with outside resources to help individuals reach their set goals. This includes: County Case Managers, PCP's, Drug and Alcohol counselors or out/in patient facilities and housing coordinators. All of these entities come together in the individuals life to assist in significant ways. Linkages of support are always offered and all resources as well. Clients are also given bus passes to be able to attend all their appointments and or grocery shop. They are also given transportation by staff, if needed. During these past few years with COVID-19, staff has educated all clients about the disease. Staff has also assisted clients with PPE's as needed. Staff continuously educates all the clients about COVID-19 and all relevant diseases, as the need arises. Staffing for Stasis program consists of: 1- Resident Advisor, 4-Client Service Providers, 2-Monitors, 1-Program Director.

CORE CONCEPTS:

- **Community collaboration:** individuals, families, agencies, and businesses work together to accomplish a shared vision.
- **Cultural competence:** adopting behaviors, attitudes and policies that enable providers to work effectively in cross-cultural situations.
- **Individual/Family-Driven, Wellness/Recovery/Resiliency-Focused Services**: adult clients and families of children and youth identify needs and preferences that result in the most effective services and supports.
- **Access to underserved communities:** Historically unserved and underserved communities are those groups that either have documented low levels of access and/or use of mental health services, face barriers to participation in the policy making process in public mental health, have low rates of insurance coverage for mental health care, and/or have been identified as priorities for mental health services.
- **Integrated service experiences:** services for clients and families are seamless. Clients and families do not have to negotiate with multiple agencies and funding sources to meet their needs.

Please select core concepts embedded in services/ program: *(May select more than one)*	**Please describe how the selected concept (s) embedded** :
Community collaboration	Individual/Family-Driven, Wellness/Recover/Resilience-FocusedServices

Access to underserved communities

Choose an item.

Integrated service experiences

Stasis works with numerous agencies to be able to help an individual with any barrier that is hindering them from accomplishing goals, and meeting their own needs. The homeless community is drastically underserved for many reasons. Limited resources and required persistence in engaging them contribute to the large number of homeless on our streets. Stasis serves 28 chronically homeless individuals at one time, and an average of 22 County residents per year. Additionally, the agency participates in Coordinated Entry and MAAP, a system built around community collaboration to efficiently provide housing to homeless, mentally ill and those individuals with a diagnosed disability in our community.This creates a one stop opportunity for homeless individuals to be assessed, gather documents, and matched to a housing program while working with one service provider. Recovery is in all aspects of the program to help promote progress towards recovery with the encouragement and support that is given to all individuals. Family support will play a big part in all individuals road to self sufficiency and recovery.

PROGRAM OUTCOME & GOALS
- Must include each of these areas/domains: (1) Effectiveness, **(2)** Efficiency, **(3)** Access, **(4)** Satisfaction & Feedback Of Persons Served & Stakeholder
- Include the following components for documenting each goal: (1) Indicator, **(2)** Who Applied, **(3)** Time of Measure, **(4)** Data Source, **(5)** Target Goal Expectancy

1. ***Effectiveness-***
   a. **Hospitalizations and Inpatient Crisis Services**

Hospitalizations refers to any hospital admissions and crisis stabilization lasting longer than 24 hours and is given by providers who meet specific regulations and who are licensed to provide these specific services. These episodes were documented by staff per incident reports and by the discharge papers that clients bring upon discharge. Hospital stays include CRMC, CCMC, Exodus, CBHC, Kaweah Delta or any other psychiatric facility that places a hold on the client. The clients that are counted are current or were current during the FY 22-23.

I. *Objective:* To prevent hospitalizations and get Crisis services for clients served.
II. *Indicator:* Percent of clients who were hospitalized or received crisis services.
III. *Who Applied:* All clients served by the program that experienced a hospitalization/ Inpatient Crisis Services due to a mental health condition. The program closely monitors all of clients medication intake and all doctors's appointments that are relevant to providing care and support towards stability and recovery for client.
IV. *Time Measured:* FY 22-23
V. *Data Source:* Incident reports and clients discharge paper work.
VI. *Goals:* To decrease hospital visits/crisis services and or stays for all clients after being accepted to program.
VII. *Outcome:* **34% (12 out of 35)** of clients served, were hospitalized during FY 22-23. Out of the 12, the majority were the same three clients.

b. Follow up from hospitalization inpatient crisis services

For client's who received inpatient crisis services, the program would speak with the discharge nurse from facility whom typically calls to validate housing for client. Staff is to provide timely follow up services once client is discharged back to program, after they are deemed stable by medical professionals. Upon arrival staff will obtain discharge paper work and document any changes of dx or medications. Staff will also make reminders for follow up visits scheduled for client to their psychiatrist, this will happen all within 24- 48 hours. Staff will assist in making new goals for a plan to help eliminate future inpatient crisis services.

I. *Objective:* To prevent crisis inpatient services in the future by establishing goals or use of coping skills set by the client to work towards.

II. *Indicator:* Incident reports, discharge paper work, percentage of clients who received inpatient crisis services.

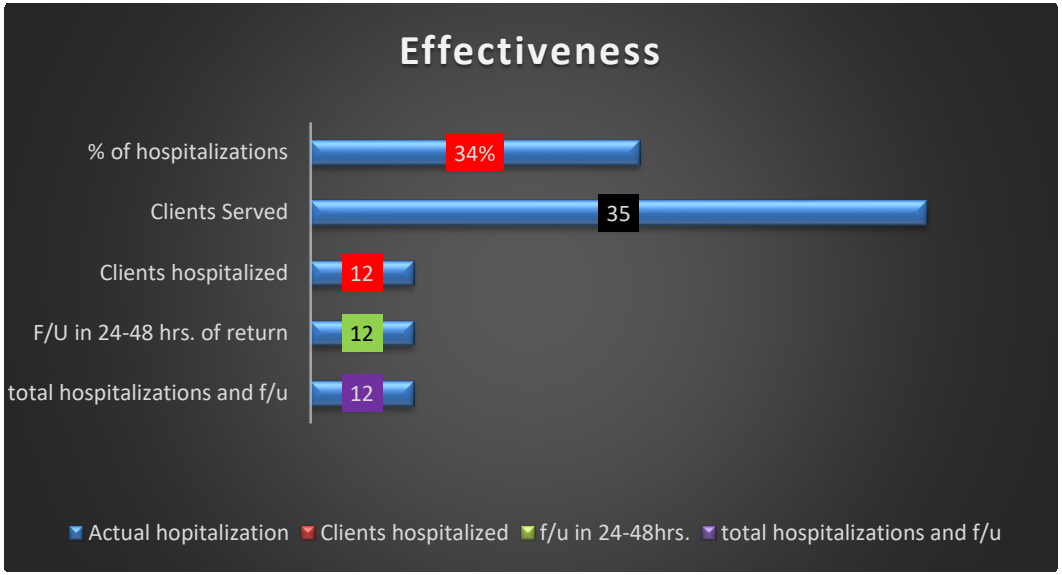
III. *Who applied:* Clients who are residents of the program and received inpatient services for FY 22-23.

IV. *Time of Measure:* FY 22-23

V. *Data Source:* Individual Service plans, Incident reports, discharge paper work, communication from professionals assisting resident.

VI. *Target goal expectancy:* Stasis implements daily medication reminders which holds residents accountable to take medications as prescribed. Stasis also keeps records of next appointments for PCP and psychiatrist to be able to remind clients. The reminders have helped significantly in maintaining stability with all residents and less inpatient crisis services. The target goal for all residents is to have them be able to independently take medications on their own without daily staff reminders and attend all appointments that assist in their well being and remain stable.

VII. *Outcome:* **34%** of residents served received inpatient crisis services by licensed providers within the FY 22-23. That is up to a 28% increase than last FY report, **(the majority of the increase were due to the same 3 clients).**



2. ***Efficiency-***

The program and staff believe that social activities and social groups play a big factor in improving mental health and boosts overall mood and engagement. The residents have given a lot of energy and effort to provide self help and over all well being. The program has seen desired results with residents who partake in groups to promote well being.

a. Social activities (resident counsel meetings,arts & crafts, music, games, karaoke, dinner and breakfast social, coffee social, birthdays, physical activity) and engagements

Residents will engage in social activities that will help with well being, socialization skills, and develop friendships.

I. *Objective*: To increase residents social engagements, overall activities improve self-esteem, confidence and decrease isolation.

II. *Indicator*: By the amount of times the clients were physically seen by staff and engages.

III. *Who participates*: Clients served by the program.

IV. *Time of measure*: FY 22-23

V. *Data Source*: Staff signed clients in, progress notes, engaged in activities with clients.The majority of activities that took place this FY year were the meals and games artas and crafts. Stasis will start to implement more of the activities now that Covid guidelines have relaxed.

VI. *Target Goal*: To have more clients engage with eachother and socialize also to spend time out of their units/rooms. This will also build and increase respect for others and build relationships.

VII. *Outcome*: **100%** of the residents have attended social activities and/or engagements provided by the program through the FY 22-23. The clients said they were happy to have some socials back in action and some said they were getting depressed since everything had been shut down. Client have been seen more without all the restrictions in place. Client are seen doing more outside of their units.

VIII. **(Stasis has implemented some/minimal, safe activities that include social distancing.)**

Efficiency 2a.	#
Clients Served	**35**
Clients engaged in Social activities	**35**
Total Participation	**100%**

b. Horticulture/ Gardening

Residents will engage in daily gardening which includes taking care of their outside plants and vegetables that they are growing. Water plant, repot plants, clip plants and take out weeds in areas.

I. *Objective:* To encourage emotional well-being. Promote movement and experience a sense of calmness and practice responsibility. Being able to partake in a beneficial activity while practicing social distancing.

II. *Indicators:* By the amount of times a client is seen participating. Client will come and share their experiences in growing a certain plant or client will share with staff what they grew.

III. *Who Applied:* Clients served by the program and who are regular residents.

IV. *Time of Measure:* FY 22-23

V. *Data Source:* Client testimonies and staff validation.

VI. *Target Goal:* To develop healthy habits, be active together, promote movement and socialization, positive interaction, have fun, develop skills.

VII. *Outcome:* **17%** or an average of 6 clients engage in horticulture/gardening. The clients say that they enjoy tending to their plants.

Efficiency 2b.	#
Clients Served	**35**
Average of clients who engaged in horticulture/gardening	**6**
Total Participation	**17%**

3. ***Access-***

There are a few avenues to be referred to the program. This outcome only counts the referrals made and sent to us via email, by hand or fax. The goal of the program is to help chronically homeless individuals with a mental health diagnosis and or disability as promptly as possible.

I. *Objective:* To provide timely service to chronically homeless individuals in need of housing assistance. To have several avenues for the consumer to access program with help of a navigator, case manager, peer support etc.

II. *Indicator:* By the number of referrals sent to the program via email, hand delivered, or fax and who accepted Stasis. Program also keeps track of bed availability.

III. *Who Applied:* Any client who is chronically homeless and or homeless wth a mental health diagnosis and/or disability.

IV. *Time of Measure:* FY 22-23

V. *Data Source:* Referral forms received by any and all who work with individual who are applying for the program and/or HMIS.

VI. *Target Goal:* To have all units to full capacity by housing those who qualify.

VII. *Outcome:* For the FY 22-23, **10 of 20** consumers that applied/referred, entered the program. *Those that did not accept Stasis housing was mostly due to being "shared housing"according to navigators. Majority of the referrals that were declined stated on it, that client did not want shared housing.*

Access through:	# of Referrals	% received	Clients entered
Coordinated Entry System in FY22-23	20	100%	10
Fresno County DBH in FY 22-23	0	0	0
Other in FY 22-23	0	0	0

***Those that meet the minimum qualifications are usually housed within 1-2 weeks. All referrals are made to Stasis and reviewed by Resident Advisor or Program Director. During screening process the client will be explained the program and they can make a choice if it is the right fit for them. The program will make every effort to keep in contact with client, whether it be directly to client and or the case manager, navigator, peer support etc.

4. ***Satisfaction & Feedback-***

Consumer surveys are conducted yearly during a one month time frame. All residents are encouraged to participate in completing surveys. The data provided is most current from July 2023.

I. *Objective:* To monitor the satisfaction of clients and gather pertinent information for service planning and overall improvements of the program.

II. *Indicator:* The survey consisted of questions/suggestions from clients and with a "on a scale of" satisfaction rate. The rating on " how satisfied are you being in this program" was done on a scale of 1-10 rate, (1-not satisfied and 10-completely satisfied). Suggestions for improvement of the program were left open space for clients to answer freely.

III. *Who applied:* Clients who were residents during FY 22-23.

IV. *Data Source: June-July 2023* Client Satisfaction Questionnaire.

V. *Target Goal:* Stasis would like to see the majority of the clients satisfied with the overall program. Stasis will strive to meet expectations and the need of the clients.

VI. *Outcome:* For the FY 22-23, Out of 35 County residents that were served/present and returned a Satisfaction Questionnare, **24 (60%)** of them were satisfied. This is based off the avareage of the surveys that were answered with ***GOOD or EXCELLENT for "quality of overall service".***

Satisfaction & Feedback	#
Clients Served	**35**
Clients who submitted survey	**24**
Clients who were satisfied with overall program	**21**
Client who submitted average or less for program satisfaction	**3**
Total percentage	**60% = Satisfied**

DEPARTMENT RECOMMENDATION(S):

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