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, 2018- June.30, 2019**
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: $94,101 **Program Actual Amount:** $94,101

Number of Unique Clients Served During Time Period: 30

Number of Services Rendered During Time Period: 7,307 Nights of Shelter and daily supportive services.

Actual Cost Per Client: $3,136.70

CONTRACT INFORMATION:

Program Type:	Contract-Operated	**Type of Program:**	Other, please specify below
Contract Term:	2/1/2016 – 1/31/2021	**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 homeless individuals who are diagnosed with a severe mental illness from the ages of 18 and older. Most residents come through the Coordinated Entry System and MAPP. The remaining residents were/are referred through Fresno County. Individuals are documented 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, 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. 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** :
	Individual/Family-Driven, Wellness/Recover/Resilience-FocusedServices
Community collaboration Access to underserved communities Choose an item.	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 homeless individuals at one time, and an average of 22 County residents per year. Additionally, the agency participates in Coordinated Entry and MAPP, a system built around community collaboration to efficiently provide housing to homeless, mentally ill individuals in our community.This creates a

Integrated service experiences	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. **Hospitalization 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 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 18-19.

I. *Objective:* To prevent hospitalizations and 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 18-19
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:* **16%** of clients served were hospitalized during FY 18-19.

b. Follow up from hospitalization inpatient crisis services

For client's who received inpatient crisis services the program would be speak with discharge nurse from facility whom typically call 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 primary 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 set by the client to work towards.

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

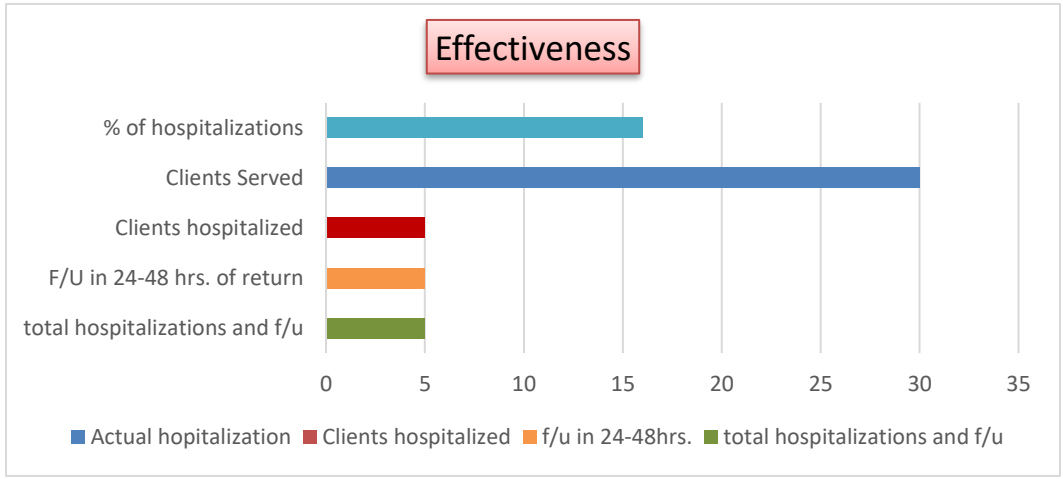
III. *Who applied:* Clients who are residents of the program and received inpatient services for FY 18-19.

IV. *Time of Measure:* FY 18-19

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

VI. *Target goal expectancy:* The program implements daily medication reminders which holds residents accountable to take medications as prescribed. 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 remain stable.

VII. *Outcome:* **16%** of residents served received inpatient crisis services by licensed providers. Some of the percentage is from the same residents who received crisis services more than once within the FY 18-19



2. Efficiency-

The program and staff believe that physical activity and social groups play a big factor in improving mental health and boosts overall mood along with better physical mobility. 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 (arts & crafts, music, karaoke, dinner and breakfast social, coffee social, birthdays) 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 client signs in, and is physically seen by staff and engages.

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

IV. *Time of measure*: FY 18-19

V. *Data Source*: Sign in sheets, progress notes

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 18-19.

Efficiency 2a.	#
Clients Served	**30**
Clients engaged in Social activities	**30**
Total Participation	**100%**

b. Physical Activity/ Fitness Group

Residents will engage in low impact/ high impact and modified physical activities**.** Activities include fitness excercises, basketball, light weights and walking.

I. *Objective:* To encourage physical and emotional well-being. Promote growth in movement. Experience new activities and help in weight control.

II. *Indicators:* By the amount of times a client sign in for group. Client complains of weight gain from medications and the client complains of not being able to get out of bed and or always tired.

III. *Who Applied:* Clients served by the program and who are regular residents and clients that complained of weight gain due to some medications.

IV. *Time of Measure:* FY 18-19

V. *Data Source:* Sign in sheet, progress notes and client testimonies.

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

VII. *Outcome:* **13%** or an average of 4 of the client engage in the weekly fitness groups. The clients say that they enjoy it and look forward to it. Some have reported that they have lost weight and gained more energy.

Efficiency 2b.	#
Clients Served	**30**
Average of clients who engaged in physical fitness -weekly	**4**
Total Participation	**13%**

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 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. Program also keeps track of bed availability.

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

IV. *Time of Measure:* FY 18-19

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 18-19, 11 of 12 consumers that applied, entered the program.

Access through:	# of Referrals	%
Coordinated Entry System in FY18-19	9	75%
Fresno County DBH in FY 18-19	3	25%
Other in FY 18-19	0	0

***Those that meet the minimum qualifications are usually housed within 1 week (depending on availability of unit). 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, weather 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 December 2018.

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 Dec 2018.

IV. *Data Source:* 2018 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 18019, Out of 30 County residents that were served/present and returned a Satisfaction Questionnare, **21 (70%)** 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	**30**
Clients who returned survey	**21**
Clients who were satisfied with overall program	**21**
Total percentage	**70%**

DEPARTMENT RECOMMENDATION(S):

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