Sutter County Homeless Services

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Sutter County Prevention Services Coordinator-Homeless Program

Homeless Services in Sutter County

Coordinated Entry System

September 2017

Project Goal- Streamline homeless services

Open Doors (Sutter County & City of Yuba City)

October 2018

Project Goal-Monthly outreach events to engage with the hard to reach population

Adventist Health Street Nursing Program

Fall 2018

Aimed at connecting area homeless with medical care

Sutter County Homeless to Home Project (H2H)

January 10, 2017 Sutter County BOS approved the Homeless to Housed (H2H) Motel Pilot Project

Project Goal- Provide emergency shelter paired with intensive case management services to Sutter County residents experiencing homelessness who are 50 years and up AND chronically ill

Sutter County Emergency Services Shelter (SuCESS)

2019

Projects Goal-Provide emergency shelter paired with intensive case management services to Sutter County residents experiencing homelessness

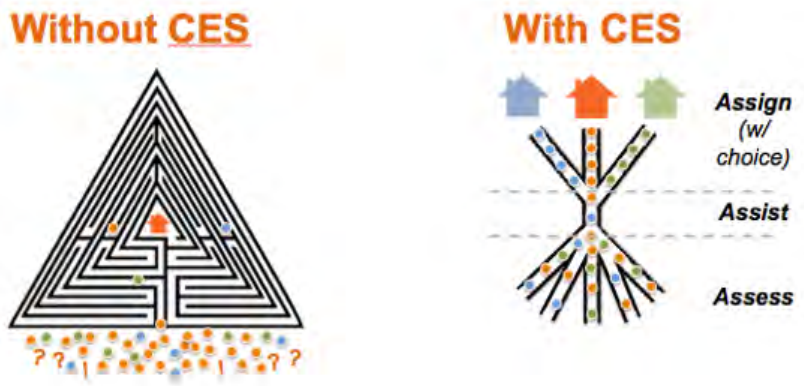
Coordinated Entry

The responsibilities and program requirement of the a Continuum of Care, were written into Public Law on May 20, 2009, the President signed the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act.

- **2009 Sutter-Yuba Homeless Consortium Established**

- The Housing and Urban Development Department directed the all Continuums of Care to establish a centralized or coordinated assessment system that would provide an initial, comprehensive assessment of the needs of individuals and families for housing and services to be in place by January 2018.

- **Fall 2017-Yuba-Sutter Coordinated Entry System was established**



YUBA/SUTTER HOMELESS COORDINATED ENTRY PROGRAM

Coordinated Entry

Single Entry Point for Homeless Services

Resource Centers and Access Points

THE LIFE BUILDING CENTER

131 F STREET, MARYSVILLE CA

749-6811

Open Monday – Friday

9:00am -3:30pm

YUBA/SUTTER HOMELESS COORDINATED ENTRY PROGRAM

HANDS OF HOPE

909 SPIVA YUBA, CITY CA

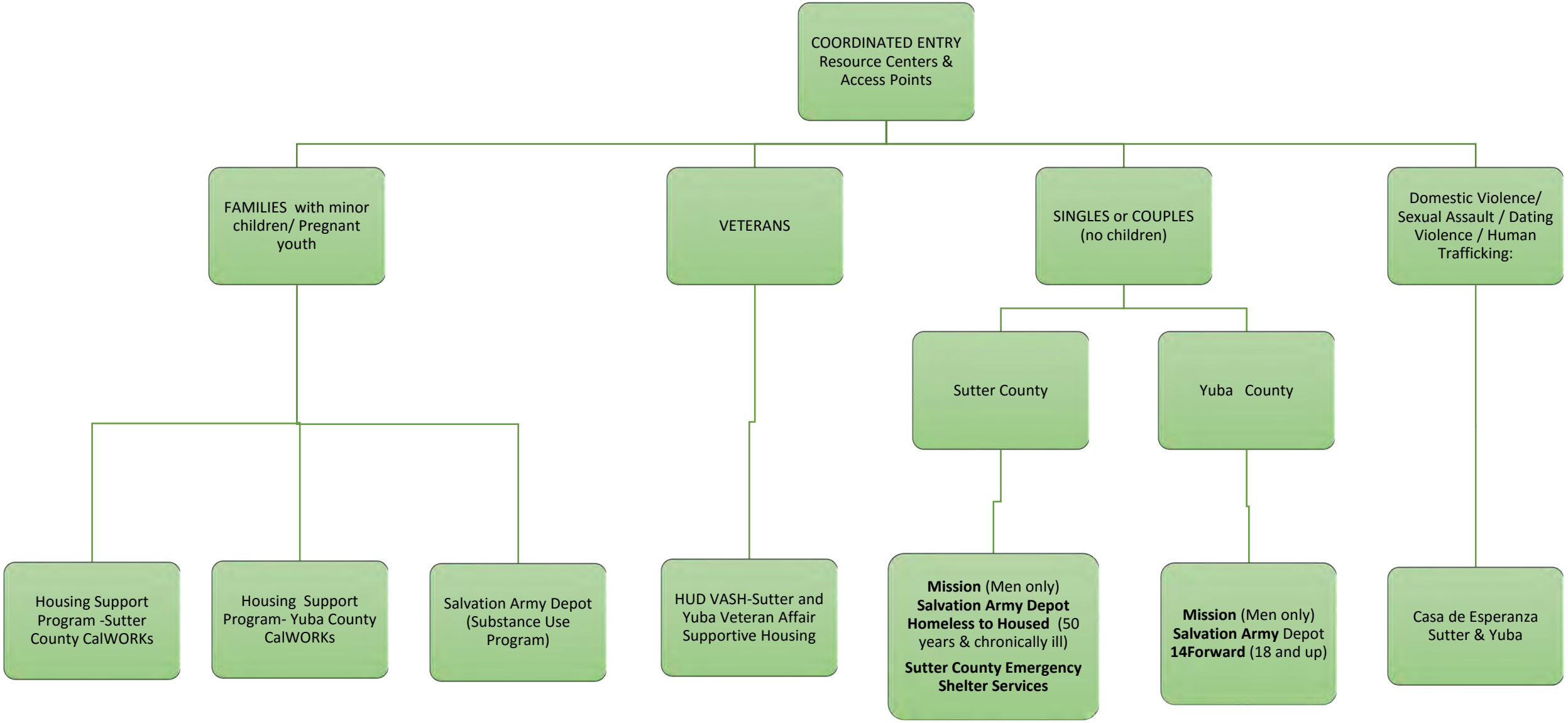
755-3491

Open Monday – Thursday

11:00am -5:00pm

* Showers & Laundry * Mentoring

*Case Management * Connection to Housing & Services


COORDINATED ENTRY Resource Centers & Access Points
FAMILIES with minor children/ Pregnant youth
VETERANS
SINGLES or COUPLES (no children)
Domestic Violence/ Sexual Assault / Dating Violence / Human Trafficking:
Sutter County
Yuba County
Housing Support Program -Sutter County CalWORKs
Housing Support Program- Yuba County CalWORKs
Salvation Army Depot (Substance Use Program)
HUD VASH-Sutter and Yuba Veteran Affair Supportive Housing
Mission (Men only) Salvation Army Depot Homeless to Housed (50 years & chronically ill)
Sutter County Emergency Shelter Services
Mission (Men only) Salvation Army Depot 14Forward (18 and up)
Casa de Esperanza Sutter & Yuba

Open Doors

Monthly outreach event at Whiteaker Hall

Services provided

- Jim Leonard & the Riverbottoms Ministry provides the meal
- Sutter Animal Services Authority
  - ✓ Rabies shots, animal license vouchers and leashes
- Coordinated Entry services (access to shelter list)
- Sutter County Public Health
  - ✓ Flu shots, Hep A vaccines, HIV testing & Narcan (treats opioid overdose)
- Adventist Health Street Nursing Program
- Sutter County OneStop
- Yuba/Sutter Veterans Services
- REST (Regional Emergency Shelter Team)
- Sutter County Eligibility
  - ✓ CalFresh program & I.D. vouchers
- Hair cuts

Adventist Health Street Nursing Program

- The Street Outreach team consists of one Nurse and one Patient Care Coordinator.
- Tuesdays and Thursdays time is split between the two coordinated entry sites & monthly at Open Doors
- The Street Outreach team conducts medical assessments with individual care plans based needs discussed.

Patient Care Coordinator Role
Make new patient appointments for individuals with no primary care doctor, schedule follow up appointments with providers based on findings, health insurance help, transportation, community referrals, coordination of services such as food resources, housing resources, cell phone sign up, as well as any other identified needs.

Nursing Role
Assessing, screening, and triaging each patient. Check vitals including blood pressure, heart rate, temperature and oxygen. Listen to lungs and heart sounds. Conduct wound checks, education on disease management, insure med compliance by checking medications and talking with doctors and pharmacies, covering cost of medications when the patient has no insurance or co-pay they cannot afford using 340B.

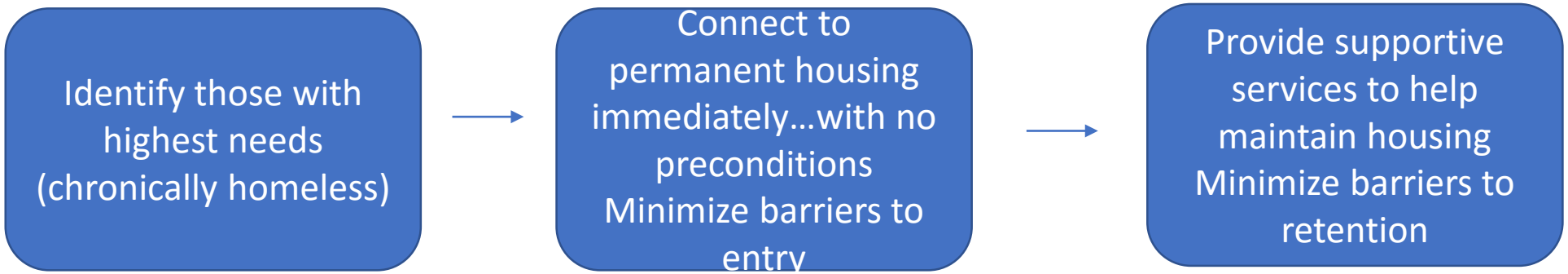
Housing First Approach

Key Principles: Everyone Is Housing Ready

1)People experiencing homelessness should be returned to or stabilized in permanent housing **as soon as possible** and connected with the resources required to sustain that housing

2)Underlying issues are **best addressed after** that person is in a stable housing environment

3)Requirement for funding



Sutter County Homeless to Housed - H2H

- The Homeless to Housed (H2H) Motel Project is a temporary, emergency no-barrier shelter for Sutter County residents 50 years and up and chronically ill.
- Provides temporary housing (in motels located in Yuba City); barrier reducing intensive case management towards a path to permanent housing and self-sufficiency
- Capacity 8-10
- 90 day program

Sutter County Homeless to Housed - H2H

Eligibility

- Must be on the Coordinated Entry list
- 50 years of age and over AND serious medical condition exacerbated by homelessness

Case management site visits

- Weekly home visits
- Client centered case plan is developed to address:
  - Housing
  - Income (employment or social security disability)
  - Establish primary care
  - Food resources
  - Budgeting
  - Landlord/Tenant relationship
  - Transportation

Post Housing Care (6 months)

- Case managers continue to conduct home visits up to 6 months providing support to participants

Sutter County Emergency Services Shelter (SuCESS)

SuCESS will be a low barrier shelter.

- 20-30 units, double occupancy
- 24 hour shelter

Eligibility

- Sutter County resident and 18 years and up

Case management site visits

- Weekly home visits
- Client centered case plan is developed to address:
  - Housing Navigation
  - Income (employment or social security disability)
  - Establish primary care
  - Food resources
  - Budgeting
  - Landlord/Tenant relationship
  - Transportation
- **Post Housing Care** (6 months)
- Case managers continue to conduct home visits up to 6 months providing support to participants

Kathleen, 71 years old living on the streets for three months after a dispute with her roommate in January 2018. Kathleen has severe dementia which made living independently no longer possible. Kathleen found the REST (Regional Emergency Shelter Team) Program which referred her to Coordinated Entry. Kathleen was enrolled into the H2H project.

Kathleen is now living in an assisted living facility.

Thank you

If you have any questions or would like additional information about anything I discussed today, please do not hesitate to contact me at:

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