California Community Reinvestment Grants (CalCRG) Program Work Plan

Grant Term: October 1, 2019 – September 30, 2021[1].

Applicant Name: Tri-City Health Center (TCHC) and Carnales Unidos Reformando Adictos Incorporate (C.U.R.A)

Funding Category: JP, MHT, SUD, SNS, and LMC

	Activity	Service Category [2]	Expected Output(s)	Expected Outcome(s)	Evidence of Completion	Start Date (Month/ Year)	Expected Completion Date (Month/Year)
1.	**Establish strong, mutually beneficial cross-referral relationship (both TCHC and C.U.R.A)**	JP MHT SUD SNS LMC	Meet to establish collaboration, goals, objectives, timelines and cross-referral protocols	Shared understanding of program deliverables	Signed Memorandum of Understanding	10/2019	10/2019
2.	**Hire 1.25 FTE Resource Case Managers to provide JP, SUD and LMC services (C.U.R.A)**	JP SUD LMC	Develop job description and advertise position Interview and hired candidates	One full-time and one part-time Resource Case Manager (RCM) are hired and onboarded	Duty statement Job offer letter Signed employment agreement	10/2019	12/2019
3.	**Hire community health workers to provide MHT, SNS and LMC services**	MHT SNS LMC	Develop job description and advertise position Interview and hire candidates	Two qualified full-time Community Health Workers (CHW) are hired and onboarded	Duty statement Job offer letter Signed employment contracts	10/2019	12/2019

[1] Grant funds may be expended only during the grant term.

[2] Include all service categories supported by each listed activity. Job Placement: JP; Mental Health Treatment: MHT; Substance Use Disorder Treatment: SUD; System Navigation Services: SNS; Legal Services to Address Barriers to Reentry: LS; Linkages to Medical Care: LMC

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4.	**Train staff to implement screening and assessment tools.** **Staff will receive online case management certification (both TCHC and C.U.R.A.)**	MHT SNS SNS LMC MHT SUD	Two CHW's will receive training by Information Systems (IS) internal trainer Two CHW's, one Clinical Director, two RCM's will complete online training	Two CHW's will be able to implement screening and assessment tools in Electronic Health Record (EHR) Two CHW's, one Clinical Director and two RCM's will obtain case management certification	Completion of internal training by IS Department Online Certification of Completion	12/2019	2/2020
5.	**Provide job placement services (C.U.R.A.)**	JP	125 clients will receive job placement services annually (250 over two years). **32 clients will be served per quarter.** Each client receives (4) one-on-one job readiness counseling sessions and (8) group job readiness workshops where clients practice role-playing for interviews, how to dress, resume-building, etc.	113 (90%) of clients will increase their skills in job search, resume writing, job interviewing, time management, life skills, hygiene and grooming, etc. **28 clients per quarter.**	Documentation in Clinician's Gateway	12/2019 (counseling sessions and group workshops are provided on a rolling basis)	9/2021
6.	**Place clients in permanent jobs (C.U.R.A)**	JP	113 (90%) of clients complete interviews with at least three potential employers. **28 clients per quarter.**	100 (80%) of clients that are placed in a job maintain their employment status for at least 6 months	Employment Agreements Documentation in Clinician's Gateway	12/2019	9/2021

Activity		Service Category [2]	Expected Output(s)	Expected Outcome(s)	Evidence of Completion	Start Date (Month/ Year)	Expected Completion Date (Month/Year)
			100 (80%) of clients that complete interviews are placed in jobs where they have sustained improvements in income **25 clients per quarter.**	100 (100%) of clients employed for at least six months are employed at or above $13.50 per hour.	Pay stubs		
7.	**Provide intensive case management services to facilitate mental health recovery.**	MHT	Provide patient navigation and coordination of services to connect client with medical and non-medical strategies to facilitate mental health recovery. Each CHW will have a caseload of 20-40 clients at any given time. CHW's will serve 150 clients per year (75 per CHW) for 2 years for a total of 1,500 patient visits (or phone calls) per year. **38 clients will be served per quarter through 375 visits or calls.**	75 (50%) of clients will be seen by a CHW within 5 days of referral. **19 clients per quarter.** 105 (70%) of clients will be seen by a Primary Care and/or Behavioral Health Provider within 15 days of referral. **26 patients quarterly.** 135 (90%) of clients improve their self-efficacy through health education and social support provided by trusted peer advocates. **34 clients per quarter.**	EHR Documentation of CHW Visit EHR Documentation of Provider Visit Patient Survey	12/2019	9/2021

Activity		Service Category [2]	Expected Output(s)	Expected Outcome(s)	Evidence of Completion	Start Date (Month/ Year)	Expected Completion Date (Month/Year)
8.	**Help clients develop Health Action Plans to facilitate mental health recovery.**	MHT	Work with 150 clients per year to complete Health Action Plans and work towards achievement of goals in their goal plan. CHW's will work with **38 clients per quarter.**	135 (90%) of clients will develop a Health Action Plan within three months of intake. **34 clients per quarter.** 105 (70%) of those will achieve at least one goal in their goal plan within a 12-month period. **26 clients quarterly** 135 (90%) of clients improve their individualized goal-setting and ability to implement self-management plans to facilitate long-term recovery. **34 clients per quarter.**	EHR Documentation of case notes EHR Documentation of case notes Patient survey	12/2019	9/2021
9.	**Provide case management for substance use disorder treatment services (C.U.R.A)**	SUD	125 clients annually (250 over two years) will receive case management and recovery support services (assessment, action plan development, and care coordination services) for	100 (80%) of clients will safely transition from Residential SUD Treatment into Recovery Residence for six months or into respective	Case notes and re-assessment with client feedback Lease or rental, or Recovery Residence agreement	12/2019	9/2021

Activity		Service Category [2]	Expected Output(s)	Expected Outcome(s)	Evidence of Completion	Start Date (Month/ Year)	Expected Completion Date (Month/Year)
			SUD treatment. **31 clients will be served quarterly.**	communities. **25 clients quarterly.** 100 (80%) of clients do not recidivate (return to incarceration). **25 clients quarterly.**	Information provided by clients and with the criminal justice system Clinician's Gateway		
10.	**Link clients to wrap around services.**	SNS	Two CHW's will be trained in the use of screening tools. CHW's will use EHR data from these screening tools to identify, address, and refer all clients to services that address behavioral health and SDOH issues. 135 (90%) of clients are connected and/or enrolled in applicable services. **34 clients quarterly.**	143 (95%) of clients will participate in at least one screening or assessment. **36 per quarter.** 143 (95%) of clients will increase ability to navigate social supports via in-creased community-clinical linkages**. 36 per quarter.**	EHR Documentation of case notes Patient survey	12/2019	9/2021
11.	**Provide linkages to medical care (Both TCHC and C.U.R.A.)**	LMC	Make initial appointment for patient with medical care provider and provide warm-handoff internal and/or fully supported external referrals for 135 (90%) of clients**. 34 clients per quarter.** Provide 450 referrals per year for 2 years or an	135 (90%) of clients will complete at least one referral to TCHC or other medical provider and receive needed services. **34 clients per quarter.** 119 (95%) of the 125 C.U.R.A. clients will	EHR Documentation of Provider Visit Clinician's Gateway	12/2019	9/2021

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			average of three referrals per patients annually. **113 referrals per quarter.** Patients will complete 150 referrals per year for 2 years. **38 referrals per quarter.** 125 C.U.R.A. clients will be referred to TCHC for medical and behavioral health care. **31 clients per quarter.**	be connected to TCHC or other medical office for primary care and behavioral health appointments. **30 clients per quarter.**			
12.	**Develop and implement outcome evaluation (TCHC and C.U.R.A)**	JP MHT SUD SNS LMC	An evaluation process documented in policies and procedures Outcome evaluation reports	Program and services implementation are measured	Evaluation policies and procedures Impact evaluations reports	12/2019	9/2021
13.	**Collect qualitative and quantitative data regarding program success (TCHC and C.U.R.A.)**	JP MHT SUD SNS LMC	Individual and program-wide success stories and statistics. Patient Satisfaction Survey.	Accurately and clearly demonstrate how CalCRG funds meaningfully improved priority population's opportunities and quality of life. 248 (90%) of 275 total clients will report that they were satisfied (had a good experience)	Write ups Reports Spreadsheets with the service they received.	12/2019	9/2021