California Community Reinvestment Grants Program Application Full Report

Applicant Information		
Applicant Organization's Legal Name: San Francisco Public Health Foundation		
Applicant Organization Type:		
☒ Community-based Nonprofit Organization ☐ Local Health Department		
Is this a Collaborative Application? Yes		
If this is a Collaborative Application, how many partners are in the collaboration, including the Lead Applicant? 2		
Federal Employer Identification Number: 94-3117093		
Secretary of State Entity Number: C1612858		
Year Organization Established: 1988		
Registry of Charitable Trust Registration Number: 071815		
Mailing Address		
Address Line 1: 375 Laguna Honda Blvd		
Address Line 2: B303		
City: San Francisco	State: CA	Zip Code: 94116
Country: United States	Non-US Territory:	Non-US Postal Code:
Payment Address (if different than Mailing Address)		
Address Line 1:		
Address Line 2:		
City:	State:	Zip Code:
Country:	Non-US Territory:	Non-US Postal Code:
Geographic Eligibility		
☒ Eligible County ☒ Eligible Census Tracts		
Eligible county: San Francisco		
Using the CalCRG Program Census Tracts map, enter the census tract(s) of the service area: 94124		

Proposal Summary

Funding Category or Categories (select at least one)

- [x] Job Placement
- [x] Mental Health Treatment
- [x] Substance Use Disorder Treatment
- [x] System Navigation Services
- [ ] Legal Services to Address Barriers to Reentry
- [x] Linkages to Medical Care

Total Amount Requested: $650,000

Of the Total Amount Requested, how much is budgeted for the Lead Applicant?
$300,000

Funding Category or Categories provided by Lead Applicant (select at least one)

- [x] Job Placement
- [x] Mental Health Treatment
- [x] Substance Use Disorder Treatment
- [x] System Navigation Services
- [ ] Legal Services to Address Barriers to Reentry
- [x] Linkages to Medical Care
- [ ] N/A (Fiscal Agent)

Executive Summary: Please describe your proposal in 3-5 sentences

The Transitions Clinic Network (TCN) program, developed in 2006 and implemented in Southeast Health Center in Bayview Hunter's Point in San Francisco, provides health and reentry services for individuals with chronic conditions returning from prison. The program is responsive to the needs as defined by the community served and led by community health workers (CHWs) with lived experience of incarceration. The TCN program has been shown to improve health and reentry outcomes among its clients. To date, the TCN program has been implemented at 17 primary care sites in California and in 12 states and Puerto Rico.

The funds requested in this proposal will be used to support continuity of healthcare from prison to the community, enhance behavioral health and employment services, and create wellness programs with the goal of improving health, raising economic stability and promoting the quality of life of individuals with chronic diseases returning from prison to San Francisco. The TCN program was predicated on the notion that the health care system has a critical role in mitigating the harms of mass incarceration. These funds will be used to directly support the communities and individuals most impacted by these policies.

Form 990, Exempt Organization Tax Return Information
Has the applicant ever filed a Form 990 with the Internal Revenue Service? Yes
What was the tax year of the most recently filed Form 990? 2018
Part VIII Statement of Revenue
Contributions, gifts, grants and other similar amount:
Line 1a Federated Campaigns: $0
Line 1b Membership Dues: $0
Line 1c Fundraising Events: $0
Line 1d Related Organizations: $0
Line 1e Government Grants (contributions): $0
Line 1f All Other Contributions, Gifts, and Grants: $97,813
Line 12 Column A, Total Revenue: $97,813
Part IX Statement of Functional Expenses
Line 22 Column A, Depreciation, Depletion, and Amortization: $0
Line 25 Total Functional Expenses:
Column A: $260,150
Column B: $170,481
Column C: $89,669
Column D: $0
Part X Balance Sheet
Line 1 Column B, Cash: $460,720
Line 2 Column B, Savings and Temporary Cash Investments: $2,937,378
Line 16 Column B, Total Assets: $3,427,327
Line 19 Column B, Deferred Revenue: $0
Line 26 Column B, Total Liabilities: $2,942,704
Line 27 Column B, Unrestricted Net Assets: $484,623

Contact Information

Relationship: Applicant or employee of applicant
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Relationship: Collaborative Application Partner
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Mailing Address: 2401 Keith St, San Francisco, CA 94124

Collaborative Application Partners

Partner Organization Legal Name: San Francisco Department of Public Health
Partner Organization Type: Local Health Department
Amount budgeted for partner: $350,000
Funding Categories: - Mental Health Treatment
1. What is this partner organization's mission?
The mission of the San Francisco Department of Public Health is to protect and promote the health of all San Franciscans.

The San Francisco Department of Public Health shall: 1) Assess and research the health of the community 2) Develop and enforce healthy policy 3) Prevent disease and injury 4) Educate the public and train health care providers 5) Provide quality, comprehensive, culturally-proficient health services 6) Ensure equal access to all.

The mission of the Southeast Health Center (SEHC) is to protect and promote the health of all residents in Bayview Hunter's Point (BVHP) and to provide quality, comprehensive, culturally-proficient health services that are accessible and responsive to the community's needs.

The Transitions Clinic Program provides a patient-centered primary care medical home for individuals with chronic health conditions returning from incarceration. This program, designed in partnership with formerly incarcerated individuals, is based within safety-net community health centers in neighborhoods most impacted by incarceration.

The Southeast Health Center Transitions Clinic Program provides: 1) Linkages with correctional partners to provide continuity of care 2) Easy access to comprehensive primary care 3) Culturally competent, patient-centered medical services 4) Community health workers with a history of incarceration as part of an integrated medical team 5) Close partnerships with local reentry organizations to address social determinants of health.
2. Describe this partner organization's core competencies (i.e. what does this partner organization do well).
Southeast Health Center (SEHC) is a full service health clinic that has provided affordable, comprehensive and quality care to residents of the Bayview Hunter's Point area since 1979. Southeast provides primary, mental health, dental and vision care.

Southeast Health Center has skilled, caring and knowledgeable doctors, nurse practitioners, nurses, a podiatrist, a pharmacist, a nutritionist, dentists, eye doctors, social workers, insurance specialists and other support staff. Members of Southeast's staff are proficient in most of the languages spoken in the neighborhoods we serve.

Southeast's patient panel is 50% African American and while the services are open to all races and ethnicities, there is a particular emphasis on meeting the cultural needs of African Americans.
The Transitions Clinic Network (TCN) program is housed at the Southeast Health Center in part because the Bayview neighborhood population has been disproportionately affected by incarceration and the War on Drugs.

The TCN program is a primary care based intervention that provides services for individuals with chronic conditions exiting prison. The strength of the program lies in its emphasis on meeting clients' re-entry needs and addressing social determinants of health. The TCN program has been hiring and training Community Health Workers with incarceration experience at SEHC since 2006. Currently two SFDPH CHWs who have direct knowledge of the employment and re-entry challenges faced by the client population are working in the Transitions Clinic program. An additional TCN program asset has been the partnership with the San Francisco Public Health Foundation that provides complimentary supports to the TCN clients.
3. List this partner organization's board members and staff that will be working on the proposed services, a description of their background, and their roles and responsibilities. Please include a description of if and how this partner organization's board members, decision makers, and/or staff have been directly impacted by the War on Drugs.
Ronald Sanders, Senior CHW, CASC, Southeast Health Center. Ronald Sanders is the Senior Community Health Worker (CHW) at the Transitions Clinic Program at Southeast Health Center. Ron completed his CHW certification in the Post Prison Health Worker program at City College of San Francisco as well as his Certified Alcohol and Drug Counselor (CASC) certificate. He has dedicated himself to provide services to communities impacted by incarceration for over a decade. Having overcome incarceration, homelessness and addiction himself, Ron understands patients' challenges and acts as a role model for those looking to end their cycle of incarceration. Ron also trains and mentors other CHWs with histories of incarceration. Ron was previously appointed by the Mayor of San Francisco to the San Francisco Reentry Council. He's received numerous awards, including the national Esther M. Holderby Dedicated CHW Award in 2014 for excellence in the CHW field and the "In the Trenches" Award from the Senior Ex-Offender Program in 2015. Through his service and mentoring, Ron is leading a national movement of CHWs with histories of incarceration as part of the solution to halt the revolving door of incarceration. Ron's role on this project will be to assist with the development and the group wellness activities, client advisory board, and program to reduce barriers to economic advancement. He will be recruiting and engaging clients into the proposed services.

Keith Seidel, MD Medical Director, Southeast Health Center. Keith is a practicing family physician and the medical director of Southeast Health Center in Bayview Hunter's Point in San Francisco, CA. Dr. Seidel completed a residency at UCSF. He utilizes data to identify health disparities and has spearheaded many quality improvement endeavors aimed at improving the health outcomes of the African American Community. Keith's role on the project will be to hire and supervise the project mental health provider.

Southeast Health Center's Leadership Team also includes Judy Lizardo as Nurse Manager, Gwen Smith as Integrated Health Program Coordinator, and Eileen Villaruel as Practice Manager. Southeast has a Consumer Advisory Panel and an active Quality Improvement Committee. Southeast Health Center is part of the San Francisco Department of Public Health (SFPDH). SFDPH is managed by the San Francisco Health Commission, currently comprised of six Health Commissioners and their individual biographies are included below.

On March 19th, 2019 the Health Commission unanimously passed a resolution to recognize incarceration as a public health issue and directed the Department of Public Health to develop proposals to prevent incarceration, improve data on this topic, and expand discharge planning and coordination among agencies serving this population.

Edward A. Chow, M.D. Commissioner Chow is an internal medicine specialist who has been in practice in San Francisco for over fifty years. He is President and CEO of Jade Health Care Medical Group, affiliated with the Chinese Hospital Health System. Previously he was Executive Director of the Chinese Community Health Care Association, and Chief Medical Officer of the Chinese Community Health Plan. He is co-chair of the Asian American Native Hawaiian and Pacific Islander Diabetes Coalition and member-at-large of the Federation of Chinese American and Chinese Canadian Medical Societies Board of Directors. He has received numerous awards for his work in health disparities and cultural competency.

Dan Bernal, Vice President. Mr. Bernal is Chief of Staff for Congresswoman and Speaker of the House Nancy Pelosi. He has dedicated his career to public service, having served in the White House under President Bill Clinton and as a presidential appointee at the U.S. Department of Education. As Congress debated the Affordable Care Act, he supported Speaker Pelosi's efforts to build support for the legislation in California by convening diverse stakeholders and coordinating activities for Bay Area Members of Congress. He continues to serve as a valuable resource to key policy makers, and advocates in the fight to prevent repeal of the Affordable Care Act. He was appointed to the Health Commission in 2017.

Cecilia Chung. Ms. Chung is nationally recognized as a civil rights leader, advocating for HIV/AIDS awareness and care, LGBT equality, and prisoner rights. She is the Senior Strategist of Transgender Law Center and has served on a number of planning bodies, which includes the San Francisco HIV Health Services Planning Council, Transgender Community Advisory Board for UCSF TRANS and the Visioning Change Initiative of the California HIV/AIDS Research Program. She is currently serving on the Presidential Advisory Council on HIV/AIDS. She was appointed to the Health Commission in 2012.

Laurie Green, M.D. Dr. Green is the founding partner of Pacific Women's Obstetrics & Gynecology Medical Group, which was founded in 1989 with the goal of providing state-of-the-art, empathic

obstetrics and gynecology care in a woman-run, visually beautiful environment. Dr. Green is also the Founder, President, and Chair of the Board of The MAVEN Project, which engages physicians to volunteer their clinical expertise via telehealth technology to medically under-resourced communities across the country.

Tessie M. Guillermo. Ms. Guillermo is the former President and CEO of ZeroDivide, a philanthropy and consultancy that developed innovative digital equity strategies in support of low-income communities. Ms. Guillermo served in this capacity for 13 years. Prior to ZeroDivide, Ms. Guillermo was the founding CEO of the Asian and Pacific Islander American Health Forum, leading this national minority health policy/advocacy organization for 15 years. In recognition of her national leadership, Ms. Guillermo was appointed by President Bill Clinton to serve as an inaugural member of the President's Advisory Commission on Asian Americans and Pacific Islanders. She currently serves as Board Chairwoman for Dignity Health, and serves on the boards of the Marguerite Casey Foundation, the Nonprofit Finance Fund.

James Loyce Jr., M.S., President . Mr. Loyce is a Public Health and Non-Profit professional and advocate with over 35 years of experience. He began his career in the Non-Profit Sector in clinical staff positions progressing over time to the role of Executive Director/CEO. His advocacy work included co-founding The Black Coalition on AIDS and serving on numerous Boards of Directors for Non-Profits. He also has been involved in local, state and federal health policy advocacy. In the public sector, Mr. Loyce served the City and County of San Francisco in a variety of senior administrative roles that spanned health policy, budget development and advocacy at local, state and federal levels. He retired from the San Francisco Department of Public Health as a Deputy Director in 2007 after 20 years of service.

4. Describe this partner organization’s experience providing services in its community/service area, and how those relate to the proposed services in this grant application.

Southeast Health Center has hosted the Transitions Clinic Network (TCN) program since its development in 2006. Southeast Health Center’s leadership was instrumental in the development and successful implementation of this innovative primary care based intervention to provide quality patient-centered services to chronically ill individuals returning from incarceration. In fact, Southeast Health Center was chosen for the TCN program specifically because it was housed in the community most impacted by incarceration and the war on drugs and had a long track record of providing quality services African American patients in Bayview Hunters Point. Even still, it was clear that the standard services were not meeting the complex needs of people impacted by the criminal justice system. Hence, Southeast Health Center’s dedication to partnering with TCN to implement a new model of care. Spearheaded by the clinic director at the time, Dr. Mark Ghaly, the TCN program began in full in 2006. Under Dr. Ghaly’ s leadership the clinic systems were transformed to accommodate a new primary care team member- a CHW with a history of incarceration. The TCN program model that was created and developed at Southeast Health Center is now a national model of healthcare for individuals impacted by the war on drugs and has been implemented in over 30 health systems in 12 states and Puerto Rico by the TCN. Southeast Health Center continues to provide primary care

services to community members of Bayview Hunters Point and has expanded addressing the social determinants of health beyond just its clients returning from incarceration. Southeast Health Center serves all individuals and their families in the community most impacted by the War on Drugs in San Francisco.

Southeast Health Center serves a larger population than the TCN program (3,825 clients). The full clinic population, as with the full SF DPH clinic population, includes fewer than 40% of clients are formerly incarcerated.

The TCN program at Southeast Health Center serves 100% formerly incarcerated clients. The new social work position proposed in this CRG funding application will be working in the TCN program and will serve only formerly incarcerated clients.
5. Of the clients this partner organization has served in the last 12 months, have at least 40% been formerly incarcerated in prison? No
6. Of the clients this partner organization has served in the last 12 months, have at least 75% been formerly incarcerated in prison? No

Organizational Capacity

1. What is your organization's mission?

The mission of the Transitions Clinic Network (TCN) is two-fold: 1) to improve the health and well-being for individuals with chronic conditions returning from prison and to 2) to provide careers for people with histories of incarceration as community health workers (CHWs) in the healthcare sector. TCN is a program of the San Francisco Public Health foundation (SFPHF) that provides capacity building to healthcare systems in communities disproportionately impacted by incarceration to ensure healthy reintegration for chronically ill individuals returning from prison. TCN works with existing health systems to implement the Transitions Clinic (TC) model of care that includes hiring and embedding CHWs with histories of incarceration into the primary care team, creating linkages between the prison and health systems and enhancing client centered clinical services like behavioral health services, medication assisted treatment (MAT), and hepatitis C treatment. In San Francisco, TCN has been collaborating with San Francisco Department of Public Health (SF DPH) to provide high quality healthcare services at Southeast Health Center in Bayview Hunter's Point since 2006. TCN has served over 2,500 individuals returning from prison to the Bayview. SFPHF is a fiscal sponsor that provides support for resource development, strategic planning, human resource administration, book keeping, non-profit tax ID solutions or other services so that partnering agencies, like TCN, are more able to focus on their strengths to better serve their communities. These funds will be used to support the TCN program at Southeast Health Center.

2. Describe your organization's core competencies (i.e. what does your organization do well).

The Transitions Clinic Network excels at transforming existing primary care systems to be more effective providers of healthcare and reentry services for individuals with chronic conditions returning to their communities. TCN's core competencies include: 1) capacity building (training and coaching) for existing health systems to transform their systems to improve healthcare and reentry outcomes for individuals with chronic conditions returning from incarceration; 2) workforce development to create career opportunities for individuals with histories of incarceration as CHWs in the healthcare sector and 3) direct client services including quality cost-effective healthcare services for individuals with complex chronic medical conditions in San Francisco's Bayview Hunter's Point. At Southeast Health Center, the site of this proposed project, TCN in collaboration with SF DPH, has transformed the healthcare system to more effectively meet the needs of people with chronic conditions returning from incarceration. This includes: 1) linking clients from state and federal prison to the clinic; 2) integrating CHWs with histories of incarceration into the primary care team 3) supporting robust re-entry services through relationships with community based social service agencies and 4) providing mentorship and social support for individuals in our program through CHWs and wellness activities. Our clinical program has been shown to reduce emergency department utilization, reduce preventable hospitalization and reduce parole and probation violations (Wang et al., 2012; Shavit et al., 2017; Wang et al., 2019)

3. List board members and staff that will be working on the proposed services, a description of their background, and their roles and responsibilities. Please include a description of if and how the organization's board members, decision makers, and/or staff have been directly impacted by the War on Drugs.

Joseph Calderon, CHW, Lead Community Health Worker (CHW), Transitions Clinic Network (TCN). At the age of 23 Joe started serving a life sentence. After nearly 20 years in prison he began to explore ways to give back to society upon his release. Joe is a 2018 JustLeadershipUSA Leading with Conviction Fellow. He served on the San Francisco Reentry Council and the Equity Advisory Committee with the San Francisco Human Rights Commission. Joe graduated from City College's Post-Prison Health Worker Certificate program. He trains and mentors TCN CHWs nationally. He has a passion for working with diverse and disenfranchised populations, leveraging his personal experience with incarceration to advocate the ideals of social justice and community investment. Joe is currently working on a degree in Public Health. His role on this project will be to develop, implement and oversee group wellness activities, client advisory board, and program to reduce barriers to economic advancement. Ronald Sanders, Senior CHW, CASC, Southeast Health Center. Ron is the Senior CHW for the TCN Program at Southeast Health Center. He completed his CHW certification in the Post Prison Health Worker program at City College of San Francisco as well as his Certified Alcohol and Drug Counselor (CASC) certificate. He has been providing services to communities impacted by incarceration for over a decade. Having overcome incarceration, homelessness and addiction himself, Ron understands client's challenges and acts as a role model for those looking to end their cycle of incarceration. Ron trains and mentors other CHWs with histories of incarceration and was appointed by the Mayor of San Francisco to the San Francisco Reentry Council. He's received numerous awards, including the national Esther M. Holderby Dedicated CHW Award in 2014 for excellence in the CHW field and the "In the Trenches" Award from the Senior Ex-Offender Program in 2015. Through his service and mentoring, Ron is leading a national movement of CHWs with histories of incarceration seeking to halt the revolving door of incarceration. Ron's role on this project will be to assist with the development and the group wellness activities, client advisory board, and program to reduce barriers to economic advancement. He will be recruiting and engaging clients into the proposed services. Shira Shavit, MD, Executive Director, Transitions Clinic Network. Dr. Shavit has been providing health care to patients and families impacted by incarceration for over a decade. In addition to acting as Executive Director for the TCN, she directs the TCN program at Southeast Health Center in San Francisco's Bayview Hunter's Point neighborhood and the volunteer Medical Discharge Planning clinic at San Quentin State Prison. She worked as a consultant to reform healthcare systems in California State prisons with the California Department of Corrections and Rehabilitation from 2006-2011. Dr. Shavit is a Clinical Professor of Family and Community Medicine at the University of California, San Francisco and received the Robert Wood Johnson Community Health Leader Award in 2010. She received her MD at Rush University in Chicago and completed her residency in Family Medicine at UCSF. Her role on the project will be to oversee all program development and implementation to insure fidelity to the Transitions Clinic model, ensure effective collaboration between TCN and its partners and train new

mental health staff at Southeast Health Center.
Anna Steiner, MSW, MPH, Program Manager, Transitions Clinic Network. Anna is TCN's Program Manager. Before joining TCN, she served as Program Advisor for the Office of Viral of Hepatitis Prevention as well as the Correctional and Women's Health Coordinator for the Sexually Transmitted Diseases Control Branch at the California Department of Public Health. Throughout her career, she has worked to promote health equity and build capacity among those facing systematic and institutional barriers to accessing health care, including people who use drugs, formerly incarcerated and homeless individuals. Anna volunteers as lead discharge planner for the Medical Discharge Planning Clinic at San Quentin State prison. Anna's will be program manager for this project, provide medical discharge planning services at San Quentin state prison, train new mental health staff at Southeast Health Center and provide assistance in hiring new program staff.
Keith Seidel, MD Medical Director, Southeast Health Center. Keith is a practicing family physician and the medical director of Southeast Health Center in Bayview Hunter's Point in San Francisco, CA. Dr. Seidel graduated from University of Illinois College of Medicine Chicago in 1995 and has been in practice for 23 years. He completed a residency at UCSF Medical Center. He leads the San Francisco Health Network in utilizing data to identify health disparities and has spearheaded many quality improvement endeavors aimed at improving the health outcomes of the African American Community. Keith's role on the project will be to hire and supervise the project mental health provider.
Penny Eardley, Executive Director, San Francisco Public Health Foundation. Penny brings 30 years of experience in non-profit leadership with a record of successful team management, fiscal responsibility, fund development and strategic planning. Working in and with safety net clinics, residential treatment programs, public radio and public affairs, education programs for youth and other human service groups Penny has broad experience with community agencies. She has won several awards, including the designation as outstanding Santa Barbara County Public Health Professional in 2001. She received her B.A. in Political Science from Michigan State University and has completed subsequent training in financial management, grant writing, personnel management, organizational development and life coaching. Penny and her team will be overseeing the contracting, fiscal management and fiscal compliance of the grant. The TCN program was developed by the Post Release Wellness Project (PRWP), collaboration between UCSF physicians, City College of San Francisco, and Legal Services for Prisoners with Children an advocacy organization. One of the core values as defined by the PRWP was to ensure that the people impacted by the criminal justice system are involved in the ongoing development, implementation and evaluation of the program. To address this goal, TCN has established a community advisory board and national advisory board both which has at least 50% of people with histories of incarceration at all times. Also, embedded within the clinical program are CHWs with histories of incarceration that provide continuous feedback and guidance in both the day to day programs and larger program development. For this project, on the TCN side, this CHW lead is Joseph Calderon and on the Southeast Health Center side the CHW lead is Ronald Sanders.

4. Describe your organization's experience providing services in your community/service area, and

how those relate to the proposed services in your grant application.
The Transitions Clinic Network program was established in San Francisco in 2006, a result of the Post Release Wellness Project (PWRP). The PRWP was collaboration between University of California, San Francisco (UCSF) physicians, City College of San Francisco Health Education faculty (CCSF) and Legal Services for Prisoners with Children advocates (LSPC). The goal of the PRWP was to identify the health needs of community members with chronic conditions returning from prison and to develop an intervention in the primary care setting to address those needs. Through a series of community focus groups with individuals with chronic medical conditions, health care providers with histories of incarceration, and mothers who had been impacted by incarceration the Transitions Clinic Network (TCN) program was developed. Implemented at Southeast Health Center in 2006, a SF DPH primary care clinic, the TCN program provides the following services to individuals with any chronic (physical, mental or substance use) condition who is returning from state or federal prison: primary medical care, HIV treatment and prevention, hepatitis C treatment, psychiatric services, pharmacy services, substance use treatment, dental care, urgent care, specialty medical services, nutrition, smoking cessation and a food pharmacy.

CHWs with histories of incarceration are embedded within the healthcare team at Southeast and outreach to clients during incarceration and post- release to engage them into services at the clinic. CHWs connect with incarcerated individuals via written correspondence or get referrals from the volunteer TCN discharge planner at San Quentin State prison. Otherwise, the CHW outreaches to parole and probation to connect with recently released individuals.

The CHWs help clients overcome their mistrust of the community healthcare system that is reinforced by substandard care they receive in California Department of Corrections and Rehabilitation (CDCR). The CHWs help the clients navigate the complex health system and the fragmented social service system to address their reentry needs. The CHWs provide support in getting identification, housing, employment, education, legal services, and family reunification. They also provide mentorship and support social inclusion. CHWs advocate on behalf of the clients to healthcare and social service agencies and participate in the San Francisco Re-entry Council to advocate on behalf of clients' needs more broadly to policy makers.

CHWs also act as cultural interpreters between the health care providers and the clients during clinic visits improving communication and client health outcomes. In this grant application, we are requesting funding to further improve the services we provide at Southeast Health Center. We are requesting funds to improve 1) behavioral health services by hiring a full time mental health clinician that would only be dedicated to TCN clients 2) create support groups to improve the well-being and social inclusion of our clients 3) advance the economic opportunity of our clients by providing resources that address barriers we have encountered to clients' employment (such as transportation, technology literacy and supplies).

5. Current process questions

a. Do you refer clients to outside organizations?Yes

If yes, please describe your policies, process, and approach to doing so

The reentry needs of the clients that we serve (the social determinants of health) are equally, if not, more important to the medical care of our clients and the community that we serve. Our model of healthcare delivery is predicated on robust relationships with outside organizations in our community that provide important services to our clients to address their reentry needs. Therefore our clinical policies include unique staff positions to create, manage and maintain these relationships. These staff is our CHWs with lived experience of incarceration.

The CHWs both work embedded within the medical team and have the flexibility to collaborate with community partners. The CHW positions are crafted to allow the CHWs to spend at least half of their work time outside the clinic itself in order to build these relationships. The CHWs identify community partners in the following domains: housing, substance use treatment providers, health systems (emergency departments, hospitals, other primary care clinics), faith-based providers, advocacy agencies, legal services, mental health clinics, educational institutions, job training organizations, re-entry councils, health plans, family and peer networks, and government benefit agencies (i.e. social security, DMV).

When the CHW is hired, part of their training includes identifying a lead contact at each organization, describing the services and eligibility criteria for services, and setting up a plan to stay in regular contact with the organization. We take the approach that organizations we refer to should be vetted and effectively follow through on their commitments. The CHW is therefore also trained to assess the quality of services by establishing the organizations reputation in the community and getting feedback from clients who received their services.

We are responsible to our community to refer our clients to quality services and will not refer to agencies that do not follow through with their commitments or replicate the criminal justice system. Another approach we take for referrals is the warm-hand off model. By establishing relationships with organizations staff the CHWs are able to ensure a warm-hand off to the partner organization. This includes a range of mechanisms from a phone call introduction to accompanying the client to introduce them to the partner organization in person.

b. Do you have a culture of communicating with referral organizations about clients? Yes

If yes, please describe

Referrals to partner organizations are an intrinsic piece of the TCN program. We maintain close communication with our referral organizations about the clients for the following purposes: 1) to assess the quality of services provided to our clients; 2) to advocate for the needs of our clients within those organizations and 3) to improve the health outcomes of our clients. Our CHWs develop their own unique relationships with key staff at the referral organizations and have check-ins with these

contacts on a routine basis (dependent on the numbers of clients we refer there). CHWs regularly visit referral organizations or accompany clients to the organizations. We always protect our clients' confidentiality and only communicate with referral organizations on behalf of our clients at their request with their permission.

We participate in forums that enhance communications with our referral organizations including: the San Francisco Reentry Council ongoing relationships with our founding community advisory board (made up of community based organizations), participation in community health and services fairs, and participation in our partner organizations community events. We also participate in the county-wide efforts to improve coordination between health systems and community-based organizations. Dr. Shavit, the program director, sits on the San Francisco Department of Public Health's Care Coordination Steering Committee and is a member of End Hep C SF's Executive Team.

c. Describe your follow up and engagement with clients during, and if applicable, after working with them.

Our program works to engage individuals with chronic medical conditions into healthcare services immediately upon release from prison. With the goal of getting clients an appointment with their healthcare provider in the first 2 weeks post release, the CHW outreaches to people soon to be released from prison or those just released. The CHW schedules the individual to be seen in the clinic to address their chronic conditions.

At the initial visit, the healthcare team, including the CHW assesses the health and social needs with the client and develops a shared care plan with the client. The client is then followed by the team at regular intervals depending on their medical acuity and the acuity of their reentry needs. We utilize a color coding risk stratification model (red, yellow, green) that indicates the level of needs of the client and helps guide the team in caring for the client. Red clients are most recently released and have the highest needs. CHWs are in contact with the clients on a weekly basis. Yellow clients have addressed some of their needs and have been in the community for some period of time. CHWs are in contact with the clients on at least a monthly basis. Green clients are stable in the community have met their needs and eventually transition from the enhanced program to being a regular client in the clinic. These clients graduate from the TCN program but can be seen by a regular provider at Southeast Health Center indefinitely or until they move or get private health insurance.

Medical acuity also dictates the follow up frequency, for instance when a client goes to the emergency department or is hospitalized we maintain close follow up with the client by scheduling a follow up primary care visit. In spite of this however, the client interfaces primarily with the CHW. On average, for every 2 medical provider visits the client has, they have 10 interactions with the CHW.

6. Financial questions

a. Please provide a short financial history of your organization, including sources of funding and

debt.
In 2006, Transitions Clinic Network became a sponsored project of the San Francisco Public Health Foundation. TCN has had a robust number of funding sources, including individual donations, foundation grants, federal funding, State of California funding, along with significant in-kind contributions from the San Francisco Public Health Department and the University of California, San Francisco. Grant funding has ranged from $5,000 to $1.3 million. TCN has no debt.

b. What is your organization's past federal and/or state grant experience?
Beginning in July 2012, TCN had a three year grant with the Center for Medicare and Medicaid Innovation administered through the Foundation of California Community Colleges. The goal of the grant was to implement the TCN model in 12 federally qualified health centers in 6 states and Puerto Rico. The grant totaled $6.8 million for 3 years.

In May 2019, TCN is contracting with California Department of Public Health (CDPH), Chronic Disease Control Branch (CDCB) on the CDC Prevention Forward 1815 Grant (1 –NU58DP006540-01-00) which is a 5 year grant focused on Prevention and Self-Management of Heart Disease, Stroke and Diabetes. TCN is contracting with CDPH for $61,680 for the first year of the grant.

In December 2018, we completed a contract with CDPH's CDCCB supporting implementation of the Lifetime of Wellness 1422 Grant activities supporting heart health and diabetes prevention funded by Centers for Disease Control and Prevention (CDC) within Southeast Health Center's TCN program.

c. Provide a summary of the last three financial agreements (loans, grants, incentive programs, etc.) your organization has entered into. Please include a description of your programmatic compliance and completion of deliverables.
The last three financial agreements are with the following entities: LA Care, The California Healthcare Foundation and the Langeloth Foundation. All of these agreements are grant funded programs.

In October 2018, LA Care awarded TCN $100,000 to provide technical assistance and training for up to 5 federally qualified health centers in Los Angeles County interested in developing the TCN model of care. The grant is still active and TCN is in good standing, having completed all its deliverables to date. Five LA clinics are participating in the training cohort and are currently onboarding CHWs.

In November 2018, The California Health Care Foundation awarded TCN $1.3 million dollars to expand the TCN model of care to 25 sites across the state of California in 2 cohorts within a 2 year period. This grant is still active and TCN has completed all its deliverables to date. Eleven new federally qualified health centers located in communities impacted by incarceration are currently participating in a learning collaborative and are in the process of hiring CHWs with histories of incarceration to join their primary care teams.

In January 2019, The Langeloth Foundation Awarded TCN $299,500 for technical assistance and training to up to 10 new sites in underserved areas across the United States over a 2 year period of time. The grant is still active and TCN has completed all it's with 2 new programs being implemented in Texas and Louisiana.

Priority Populations and Community

1. Problem statement/problem description

a. Describe the impact the War on Drugs and/or past federal or state drug policies have had on the populations you are serving.

The War on Drugs (WoD) has significant negative impacts on the behavioral and physical health, social inclusion, well-being and economic opportunities of people living in San Francisco's Bayview neighborhood, particularly those returning from prison.

Nationally and locally, the WoD has led to over-policing and over-surveillance of communities of color, funneling people of color into the criminal justice system and incarceration (Cooper, 2015; Sentencing Project, 2007). San Francisco's Bayview neighborhood, where Southeast Health Center is located and a majority of the city's black residents live, has been inequitably impacted. Within the city and county of San Francisco, 38% of drug arrests are of black individuals, who represent only 5% of the population (PPIC, 2019). This translates into gross inequities in incarceration. Nationally, black individuals comprise just 14% of regular drug users, but account for over half of those incarcerated in state prisons for drug offenses (Sentencing Project, 2007).

Incarceration, whether due to drug-related charges or other offenses, serves as a catalyst for worsening health (Brinkley-Rubenstein, 2013). Incarceration can harm mental health by separating incarcerated people from their partners and families. Prison policies also contribute directly to experiences of trauma and poor mental health outcomes through practices such as solitary confinement and sanctioned assault. While imprisoned, individuals may be exposed to communicable diseases such as HIV and Hepatitis C, and despite a constitutional mandate for prisons to provide medical care, this care has been grossly inadequate (Brinkley-Rubinstein, 2013). While prison health services can serve a positive role by screening for and beginning treatment of chronic diseases, individuals lose access to these services upon release and experience significant barriers to accessing care in the community. Individuals being released from prison are especially vulnerable to poor health outcomes. In the first two weeks after their release, individuals are 12 times more likely to die than the general population – the leading causes of death during this period are behavioral and chronic health conditions including overdose, suicide, cancer, and cardiovascular disease (Bingswanger, 2007).

Incarceration also creates barriers to educational attainment and employment by interrupting an individuals' educational and professional trajectory and by attaching negative labels and stigmas (Brinkley-Rubinstein, 2013; Sweeten, 2006). Residents of the Bayview are deprived of economic opportunity, with 39% of residents living below 200% of the census poverty threshold, and 36% with less than a high school education (Harder+Company, n.d.). Inequities are particularly evident among black residents of San Francisco, who are especially burdened by unemployment (18%), low educational attainment (63% have not completed high school) and homelessness (36%).

In sum, policies associated with the WoD - combined with other forms of structural racism including redlining and government disinvestment in communities of color - have devastated the Bayview neighborhood. Black residents, on average, live 10 years less than white residents, and suffer from

and numerous health conditions, such as cancer and high blood pressure, at disproportionate rates (SFDPH, 2016). WoD policies undoubtedly contribute to these poor health outcomes.

b. What aspects or issues of these impacts will your proposal focus on or address?

The TCN program at Southeast Health Center aims to support formerly incarcerated clients living with chronic health conditions in a successful and healthy community reentry. The funds requested in this proposal will be used to address structural barriers and enhance existing behavioral health and employment services, support continuity of care from prison to the community, and reduce social isolation and promote well-being among our formerly incarcerated clients. By targeting outreach to individuals who are recently released from prison – a population at an elevated risk of death – we can address an urgent public health need. Furthermore, our clinic is located in and serves the San Francisco Bayview neighborhood, which as noted above, experiences a heavy burden of arrest, incarceration, and poor health due in part to the WoD.

2. Describe characteristics of the major populations or clients that your organization has served historically, particularly in the past year. Include information about their demographics, social and economic wellbeing, family or individual challenges and strengths.

For the past 13 years, the Transitions Clinic Network program at Southeast Health Center has served individuals with chronic behavioral or physical health conditions returning to San Francisco from state or federal prison. TCN clients are primarily male (89%), African American (61%) or Latino (10%), older, and recently reentering the community (within 6-12 months of release from prison). All (100%) have been incarcerated at some point in their lives (Wang et al., 2012).

A majority of our clients lack access to economic resources – only 8% are employed, and 95% currently have access to less than $1000. Likewise, 33% have less than a high-school education and only 6% are stably housed (Wang et al., 2012).

Our clients are burdened by chronic and communicable health conditions. The most common self-reported diagnoses among our clients are posttraumatic stress disorder (46%), chronic pain (46%), hypertension (33%), depression (29%), hepatitis C (23%), and asthma or chronic obstructive pulmonary disease (26%). Almost 90% of participants reported use of illicit drugs in their lifetime (Wang et al., 2012).

A large proportion of our clients are ‘lifers’ or individuals who received a life sentence and subsequently spent decades in prison. These individuals may have additional challenges when re-integrating. For instance, many of these individuals are unfamiliar with the use of computers and the internet, and lack the technical skills to apply for jobs, housing, and access to key online medical services like patient-portals and pharmacy apps. Stigma, racial discrimination, and historical trauma related to health and correctional systems also make it difficult for our clients to navigate complicated health care and social service systems. Other challenges faced by many of our clients include pending legal issues and estrangement from their families.

Our clients also have developed numerous sources of strength. Many have participated in life-changing programs within the prison system, or have found other ways of drawing insights from their

lived experiences. Many of our clients also demonstrate a sense of personal resilience, as well as a desire and dedication to give back to their community and fulfill a sense of purpose.

a. Of the clients you have served in the last 12 months, have at least 40% been formerly incarcerated in prison? Yes

b. Of the clients you have served in the last 12 months, have at least 75% been formerly incarcerated in prison? Yes

c. If proposed activities are new, describe characteristics of the population you expect to serve.
These funds will be used to address structural barriers and enhance the services that are currently available to clients of the TCN program at Southeast. These activities all support the organizational mission to promote individuals' successful and healthy re-integration into the community.
The funds will also be used to support TCN's medical discharge clinic at San Quentin State Prison. This clinic, which is currently unfunded, connects chronically ill individuals being released from CDCR to health care within the community. Clients will receive a warm hand off to Southeast's TCN CHW and providers.
We anticipate serving clients that represent a similar demographic to those we serve now as all new services will be available to our current and future clients. The TCN primarily male (89%), African American (61%) or Latino (10%), older, and recently reentering the community (within 6-12 months of release from prison). All (100%) have been incarcerated at some point in their lives (Wang et al., 2012).
A majority of our clients lack access to economic resources – only 8% is employed, and 95% currently have access to less than $1000. Likewise, 33% have less than a high-school education and only 6% are stably housed (Wang et al., 2012).
Our clients are burdened by chronic and communicable health conditions. The most common self-reported diagnoses among our clients are posttraumatic stress disorder (46%), chronic pain (46%), hypertension (33%), depression (29%), hepatitis C (23%), and asthma or chronic obstructive pulmonary disease (26%). Almost 90% of participants reported use of illicit drugs in their lifetime (Wang et al., 2012).
Clients at San Quentin reflect a similar demographic to the clients we serve in our clinic, apart from are 100% male.

3. Provide evidence of the need and demand for services in the priority population
In 2017, 341 individuals returned to San Francisco from state prison, 73% of whom had some diagnosed medical need (California Correctional Health Care, 2018). Additionally, 3,545 people are released from the Federal Bureau of Prisons to California each year (BOP 2017). At least 200 are released to San Francisco annually and are housed temporary at a residential reentry center. According to national data, two-thirds of individuals returning from incarceration report substance use, 15-20% have a serious mental illness, and 50% report symptoms of mental illness (APA, 2000; National Commission Report, 2002). People returning from prison have high rates of hospitalization and death immediately upon release due to behavioral and chronic health concerns. One study found

the risk of death the first two weeks after release was 12 times that of a matched cohort in the community (Binswanger, 2007).

The need for pre-release planning and coordinated care following incarceration is clear. California Department of Corrections and Rehabilitation spends 1.9 billion annually on health care for individuals incarcerated within the state prison. None of this goes towards linking individuals to care upon release (California Department of Corrections and Rehabilitation, 2019). Providing harm reduction and health information and linkages to primary care systems and other health services, pre-release, can help mitigate the high risk of death and hospitalization upon release (Freudenberg, 2016; Rich et al., 2014; Wenzlow et al., 2011). While the majority of incarcerated individuals have at least one chronic health condition that requires ongoing treatment within the community, many of these individuals have never accessed primary care in the community and lack the basic knowledge of how to access the system (Boutwell, 2014; Malik-Kane, 2008). Medical discharge planning can help fill this gap by assuring that individuals understand how to navigate the system and receive the services they need and are entitled to.

Once released, formerly incarcerated people also benefit from ongoing, coordinated care. The TCN program was developed in direct response to community demand for these services and in collaboration with formerly incarcerated people. In 2006, the Post-Release Wellness Project, a consortium of UCSF physicians, faculty from City College of San Francisco and advocates with Legal Services for Prisoners with Children identified a need for coordinated, culturally responsive health services and linkages to address social determinants of health such as housing and employment. The TCN program team worked with this advisory board and other community members to collaboratively develop the TCN program at Southeast. As a further testament to the need for comprehensive, coordinated services, the TCN program has expanded to 17 community clinics throughout California and within clinics in 12 states and Puerto Rico.

4. Describe the gaps and/or barriers your organization has identified in existing programs and services (within your organization or in your community) as they relate to the proposed services in your grant application.

Prisons are constitutionally mandated to provide healthcare, but not linkage to health care services post-release. In most cases, CDCR does not have protocols to assure continuity of care to community-based healthcare services. Individuals are released without medical records and information for how and where to address their chronic health needs. Insufficient linkages to care are problematic and can cause individuals' chronic health conditions to worsen and be more likely to be hospitalized (Wang 2014). There are many opportunities for formerly incarcerated people to fall out of care. For example, in order to get a prescription refilled, they have to navigate health insurance, enroll in a county Medi-Cal managed care plan, find a primary care provider and make an appointment. Improving care coordination between the health services in prison and those in the community presents an opportunity to improve healthcare utilization and healthy re-integration of a large chronically-ill population by better connecting them to health care and social services. Discharge planning plays a key role in coordination, and we propose to sustain our currently unfunded discharge

planning program at San Quentin. Most primary care systems are not prepared to meet the complex social needs of formerly incarcerated individuals, such as housing and employment, or to address stigma and mistrust around the health care system. The TCN program addresses these needs by providing tailored behavioral and primary care services as well as intensive case management by CHWs with incarceration histories to address patients' social determinants of health.).While the TCN program significantly improves health indicators such as frequency of visits to the emergency department (Wang et al., 2012) and reduces hospitalization (Wang 2019), we have been unable to fully meet our clients' varied and extensive behavioral health needs because we do not currently have a full-time licensed clinical social worker that is experienced in working with formerly incarcerated individuals. Although there is a behavioral health provider working at Southeast, Medi-Cal reimbursement does not allow providers to provide the level of care necessary to meet the complex needs of recently released individuals. In addition, TCN's CHWs have documented several continued barriers to health and well-being among our clients. Incarceration can socially isolate individuals and contribute to family estrangement, which limits support structures that could otherwise help ease their transition back to the community. By forming a support group, we seek to address issues such as trauma, social isolation, institutionalization and disempowerment. In addition, clients have identified significant barriers to applying for and accepting jobs, such as insufficient computer skills and inadequate financial resources to cover the initial expenses of starting a new job, such as traveling to a job site and purchasing required attire or safety equipment such as work boots. We plan to address these barriers with resources provided through this grant.

Finally, while the community advisory board at Southeast has been instrumental in guiding the development of our model thus far, we seek aim to establish a client advisory board (CAB) that is specific to the TCN program to improve our services. The CAB will increase ongoing involvement of current and former clients in program planning, evaluation, and health and wellness activities.

Proposal Description, Implementation, and Goals

1. What will your organization do to bring about the change needed to solve/address the problem (e.g. we will teach formerly incarcerated individuals' industry specific and in-demand skills to help them obtain employment)? Describe in detail how your organization will implement the proposed services.

Improve health status among individuals with chronic conditions returning to the Bayview from incarceration. The San Francisco Department of Public Health (SF DPH) will employ one full-time licensed clinical social worker (LCSW) who has experience working with complex trauma, substance use disorder and systems-involved individuals to work with Southeast's TCN program clients. All new clients will be referred by the CHW to the LCSW for a baseline wellness assessment. The LCSW will utilize this assessment to determine the need for ongoing therapeutic services and care for clients, which may include evidence-based counseling such as cognitive behavioral therapy. They will work directly with clients to establish shared goals, address instability and support recovery and reintegration into the community. The LCSW will case conference with the multi-disciplinary TCN care team to assure that client's physical, behavioral and social determinant health goals are met. The TCN program at Southeast does not currently have a dedicated mental health provider. TCN clients are referred to Southeast's behavioral health clinicians who serve all Southeast clients and may not have the capacity to see TCN clients in a timely manner or provide ongoing therapy. We anticipate that increasing access to a mental health provider with expertise in working with systems-impacted individuals will improve therapeutic medication adherence, engagement in health services and the overall health and well-being of our clients. Another benefit of providing primary-care based mental health services is that individuals who may be required to receive mental health or substance use disorder services at parole outpatient clinic, a clinic tied to the carceral system, can instead receive care in the community. This increased access to mental health services in the community assures that individuals can benefit from supportive and stabilizing services without the fear of punishment. The staff at TCN is adept at communicating with parole and probation to transition clients care to the community without compromising confidentiality.This grant will support staffing of the medical discharge clinic at San Quentin State Prison. TCN's Program Manager currently holds an unfunded weekly medical discharge clinic at the prison where they provide direct support, medical records and referrals to individuals with chronic health conditions within 3 months of release. This medical discharge planner will enhance connections for individuals with chronic physical and/or behavioral health conditions returning to San Francisco directly to the TCN care team to assure they are seen within 2 weeks of release. They will also provide these individuals with a list of medications, medical records, and health and harm reduction education and facilitate communication between client, prison physician, mental health and other providers. The medical discharge planner and TCN care team will expedite access to essential health services including: medication refills, medication assisted treatment, hepatitis C and HIV medications and mental health services. Funds from this proposal will ensure that this service continue and facilitate ongoing sustainability and growth to include more individuals leaving CDCR. Funds from this grant will also support a TCN-specific client advisory board

(CAB). This will create an opportunity for current and former TCN clients to be involved in programmatic decisions, evaluation and policy matters, furthering the ability of the TCN to provide care that enhances the health status and well-being of clients returning to the Bayview from incarceration. Participating in the CAB will also give clients the opportunity to gain leadership experience that can be translated to employment and other professional opportunities.The TC CHW will facilitate CAB meetings, create agendas, take notes and report back to the TC care team and Southeast administrators. Efforts will be made to assure that CAB members' time and recommendations are respected.

Promote wellness among individuals with chronic health conditions returning to the Bayview from incarceration. The TCN at Southeast will start a bi-weekly support group to address problems endemic to formerly incarcerated clients: social isolation, trauma, addiction, disempowerment and stigma. The group will be informed by evidenced-based practices including a restorative justice framework. Group themes and structure will be adapted by the facilitator and Lead CHW to meet the needs of group members. The TCN CHW will hold focus groups with clients and the CAB to identify themes and areas of interest for support groups. All TCN clients will be referred to the support group. Many TCN clients participated in in peer-led, evidenced-based support groups while incarcerated. Most clients report having very positive experiences with these groups. By implementing similar groups in the community, the TCN clinic seeks to promote wellness, recovery and healing and create a sense of accountability and social connectedness.

Support economic opportunities for formerly incarcerated individuals accessing care at Southeast Health Center. TCN CHWs work with clients to achieve their health and reentry goals. Finding gainful employment is one of the most common goals clients set and many become employed shortly after release. A strong economy has resulted in ample work opportunities for individuals returning from incarceration to San Francisco. Many TCN clients find work within weeks of release. Rate limiting factors to gaining and sustaining employment for recently released individuals are start-up costs associated with employment as well as a basic technology gap.The TCN will employ a formerly incarcerated technology coach to work with individuals while accessing care at the clinic as well traveling to meet clients in the community, such as those staying at Geo Group transitional housing in the Tenderloin. This coach will help clients understand how to utilize their phones and basic computer skills with an emphasis on increasing health literacy. Many clients are released without any knowledge of how to use phones or basic technology, which can hinder their ability to conduct an effective job search, write resumes and apply for jobs online. Surveys of our current TCN clients demonstrate that barriers to employment include lack of resources to purchase work related supplies such as appropriate clothing, gear and tools. TCN clients lack funds to pay for the expensive transportation costs that can be associated with traveling long distances in the Bay Area for jobs that pay a living wage. Transportation is the third-largest budget item for low-income households after housing and food (PPIC 2019). To mitigate these expenses, we plan to provide travel vouchers and clothing and work related supply vouchers to ensure that clients can overcome these sometime insurmountable barriers to employment.

2. Is there evidence to validate the effectiveness of the proposed services as a means of solving the problem referenced in the Priority Populations and Community section? Yes

If yes, please describe.

The TCN program improves health and reentry outcomes for individuals returning from incarceration. A randomized control trial conducted among individuals recently released to San Francisco found that TCN clients' had 51% fewer emergency department visits in the first year post release as compared to those accessing traditional primary care (Wang, 2012). Clients in the TCN program in a subsequent study experienced a 2x reduction in ambulatory care sensitive hospitalizations and almost 60% shorter lengths of hospital stay as compared a the control group (Wang,2019).

The TCN program also reduces criminal justice contact. TCN clients had fewer parole or probation technical violations (17% vs. 33%) compared with the control group and those who were re-incarcerated, spent 25 fewer days, on average, re-incarcerated (Wang, 2019)

The proposed service enhancements will allow us to more adequately address other pressing client needs: ongoing behavioral health support, increased social connectedness, barriers to new employment and continuity of care from prison to the community.

Behavioral health support: Compared to the general population, justice-involved individuals are substantially more likely to have a history of mental illness, including psychotic illness and depression, as well as of trauma stemming from abuse. (James, D.J. & Glaze, L.E. (2006). Continued, one-on-one treatment after release has been shown to decrease PTSD symptoms and drug use among recently released individuals (Zlotnick, 2009). In addition, research suggests that formerly incarcerated individuals experience the most benefit from mental health treatment when integrated it is with services that address their social determinants of health such as housing and employment (Berrenger & Draine). The vast majority of TC N clients have some need for ongoing behavioral health care service support, and adding a full-time, specially- trained and licensed behavioral health clinician will improve mental health outcomes for TCN clients.

Improved linkages: Individuals returning from incarceration are rarely connected with primary care or mental health services following release (Social Exclusion Unit 2002; Hamilton and Belenko 2015; Lennox et al. 2012). However, discharge planning increases the likelihood that recently released individuals have a regular source of care to care (Wang, 2008). The medical discharge clinic at San Quentin will support clients transitioning from prison to the Bayview and help assure that chronically ill individuals receive timely access to essential health and reentry services.

Improved Social Support and Wellness: Formerly incarcerated individuals who feel connected to social support networks are more successful in securing and maintaining employment and housing and have better mental health outcomes (Denney, et al 2014; Harandi, 2017). Support groups facilitated by and responsive to the needs of formerly incarcerated clients will promote a sense of

accountability, social support, inter-connectedness and wellness.

Transportation has been found to be a significant barrier to accessing essential services as well as employment for individuals returning from incarceration (Urban Institute 2008) Access to appropriate clothing is an overlooked need as well (Gaynes 2005). Supporting client's access to transportation and work-ready clothing as part of their care plan will help mitigate those barriers.

a. Have other organizations used a similar model to produce the desired outcome? Yes
If yes, please describe.

The Transitions Clinic Network program has been implemented in 30 community based primary care clinics in 12 states and Puerto Rico. Over 10,000 formerly incarcerated clients with chronic health conditions have been seen at these clinics and they have been shown to improve health and reentry outcomes among these complex clients (Shavit 2017) The program has been cited as a best practice by CDCR's Council on Criminal Justice and Behavioral Health (formerly known as COMIO). Based on the documented success of Southeast's TCN, the TCN program was granted a Centers for Medicaid and Medicare Innovations (CMMI) grant in 2010 to expand the program at 13 sites nationally. More recently, the California Health Care Foundation (CHCF) committed to supporting a 25 site expansion of the TCN program in community health clinics throughout California.

3. What are the key assumptions behind your approach (what would need to be true for your approach to work) (e.g. peer support groups are effective because they provide relatable, good role models and support networks)?

We assume that we will be able to recruit and hire an LCSW and support group facilitator with a history of incarceration who are experienced with and passionate about working with clients with histories of incarceration. We are confident in our ability to do so because we are connected to several formal and informal networks of individuals and passionate about the wellbeing of formerly incarcerated people.

We assume that our clients will be interested in attending support groups, receiving coaching in technology, and direct support for employment such as bus tokens and work-ready clothing. We are confident this is the case because we have heard directly from our clients about the need for these forms of support, and because we will design the support group in collaboration with clients and TCN CHWs with a history of incarceration.

We assume there will be a substantial number of individuals returning to San Francisco upon release from prison. We base this assumption on data from previous years indicating that over 300 people return to San Francisco post-prison annually from CDCR alone. We also know that there is no dearth of people in the community we serve that has been impacted by the WoD and mass incarceration.

4. How does your organization intend to reach the priority populations?

The TCN program at Southeast serves individuals who are over 50 years old or have at least one chronic physical or behavioral health condition within 12 months of release from a state or federal prison. These enhanced services will be offered to new and existing clients.

Clients are identified and recruited in a variety of manners: prison in-reach; extensive community outreach; referrals from correctional and community based organizations and word of mouth.

Prison In-Reach: Medical discharge planner at San Quentin identifies eligible individuals returning to San Francisco through 90-day discharge list and parole notifications. Planner will ducat individuals for a medical discharge visit, discuss health concerns and facilitate a warm handoff to TCN CHWs and appointment for mental and physical health intake. Additionally, TCNB's Lead CHW attends health fairs at Solano State Prison 3-4 times a year where he shares information about the TCN program at Southeast and facilitates referrals.

Community Outreach: TCN CHWs spend half of their time doing directed outreach in the community. They have developed extensive and deep networks with local reentry organizations and recruit and follow-up with clients at residential reentry centers,), shelters, homeless encampments, treatment facilities, street corners, soup kitchens and any other location where people may be receiving reentry services.

Referrals: The TCN CHWS also attend the parole and community team (PACT) meetings and get referrals from parole officers with medically complex clients. The TCN program is also a trusted entity among community based reentry organizations and other health entities and receive direct referrals from these CBO's as well as hospitals and clinical partners who may not feel confident that they can meet the needs of these clients. TCN's lead CHW also founded and leads the Peer Reentry Navigation Network, a group for life term inmates based at parole.

Word of Mouth: Many of our clients are referred by other clients and family members. We anticipate that with the addition of an experienced LCSW, facilitated groups and other added supports, we will have even more referrals from clients.

5. Describe the client journey from beginning to end once the proposed services are fully implemented or expanded. If applicable, please describe your intake and referral processes.
Pre-release (if referred from San Quentin): Medical discharge planner at San Quentin will identify eligible individuals who are returning to San Francisco from San Quentin and offer to refer them to TCN CHW at Southeast and assist with scheduling appointment at clinic within 2 weeks of release. Discharge planner will also provide medication list, essential health records and confirmation of appointment pre-release. Services offered at the clinic include: behavioral and physical health appointment; medication refills; continuation or induction of medication assisted treatment; hepatitis C and HIV treatment; chronic pain management and connections to other social services.

Pre-appointment (if referred from community partner): CHW will schedule new client or follow-up client appointment visit with TCN team within 2 weeks of referral. CHW will get detailed information about how to contact the clients and call or text a reminder one week and one day before their scheduled appointment.

New client Intake process: New clients are greeted in the clinic waiting room by a CHW. Clients are fed breakfast and offered food from clinic-based food pantry. All new TCN clients will have an intake with a CHW, primary care provider and LCSW. These do not need to occur on the same day.

Intake with CHW: CHW will work with client to assess social determinant needs and create an action plan that includes housing, employment, family reconciliation, education and other social determinant goals. This plan is used to facilitate referrals and updated at each visit. Clients will also be referred to facilitated support groups and technology coach.

Intake with primary care physician: 45 minute intake to assess physical and behavioral health needs, provide medication refills, assess any outstanding needs that weren't addressed in prison and perform a full physical. TCN clinicians are x-waivered and can prescribe buprenorphine or refer out for methadone (medication assisted treatments for opioid use disorder). They can also begin HCV treatment for clients and prescribe naltrexone for alcohol use disorder. Individuals on psychotropic medications can be referred to Southeast psychiatrist for medication consultation if they're interested in switching or altering medications. Primary care physician can refer to other specialty services as needed.

Intake with LCSW: Clients will meet with the TCN LCSW for a full biopsychosocial assessment to inform ongoing need and assess desire for therapeutic treatment for mental health or substances use disorders. LCSW will also refer individuals to support group and help develop the curricula for this group. LCSW will assess trauma and toxic stress and will provide targeted, evidenced based modalities such as Eye Movement Desensitization and Reprocessing (EMDR), cognitive behavioral therapy techniques like applied relaxation, exposure in vivo, exposure through imagery, panic management, breathing retraining, and cognitive restructuring and dialectical behavioral therapy.

Follow-up: Based on social determinant assessment, CHW can assist individuals with completing Medi-Cal enrollment, signing up for benefits, picking up prescriptions at pharmacy, getting a state ID, navigating the social security office, and getting on housing lists, as well as connect clients to legal services. CHW can also provide warm hand-offs and help clients navigate to other supportive services, and offer transportation and housing vouchers. CHW can also advocate and assist clients with relationships with parole or probation officers. CHW can follow-up with primary care provider and LCSW depending upon need. In general, if clients are within the first few months of release, CHWs will contact them to follow up on a weekly basis. Clients who have been in the community for longer

than a few months will be contacted by CHWs approximately once or twice a month.

Once a client's health stabilizes, they understand how to utilize the health system and have met most of their social determinant goals, they 'graduate' from the TC program. Though these clients will no longer receive services from the TC CHW or LCSW, they are incorporated into the general clinic panel at Southeast Health Center and still receive all their health services at the clinic.

All these clients will still be able to access support groups and can be a member of the client advisory board.
If client is re-incarcerated, loses housing, relapses or experiences another destabilizing event, they are always eligible to be part of the program again.

6. Why is your organization uniquely suited to address the needs of your priority populations?
The TCN program at Southeast was created to address the unique health care needs of individuals returning to the Bayview from incarceration. The program, developed in 2006, aims to create a health home that mitigates negative experiences with health care service provision both inside and outside the walls.
The program is informed by and responsive to the needs of formerly incarcerated clients, as defined by these clients. Integrating CHWs with a history of incarceration into the primary care team also assures that programmatic and case management decisions are informed by individuals with lived experience. Clinic policies have been structured to support the needs of these clients. For instance, TCN clients are not subject to 15-minute late to appointment cancellation policies or other policies that may be experienced as punitive for this population. TCN's care team is highly trained and skilled and strives to address client's self-defined health and wellness goals. Clients have shared that being able to define their own health goals is a form of self-empowerment. TCN has developed best practices in working with correctional entities without unintentionally duplicating it. While parole is one of TCN's primary referral sources, TCN clients know that the clinic does not accept funds from CDCR and all services rendered in connection with the clinic are confidential and will not be disclosed to parole, probation or other correctional entities. The clinic has demonstrated its firm commitment to providing quality health care and wellness services and is a trusted entity within the community.
The TCN program has also shown to improve health and reentry outcomes for individuals returning from incarceration (Wang, 2012).

7. How have the proposed services been designed to meet the cultural, linguistic, and population-specific needs of the service recipients?
Cultural: We offer culturally non-stigmatizing mental health services. Our clients have experienced discrimination based on race/ethnicity, socioeconomic status, and their experiences with justice system. Our providers have extensive training to prevent further stigmatization and re-traumatization. Members of our care team also receive extensive training and coaching in providing culturally-responsive care to clients with a history of incarceration. The newly hired LCSW will team receive

coaching from more experienced practitioners and participate in our 11-module, online cultural humility training.

Linguistic: The vast majority of TCN clients speak English as a first language. If a TCN client were to need translation services, Southeast clinic staff speaks a multitude of languages and the staff has access to on-call skilled medical translators via phone 24/7.

Many TCN clients have a low level of health literacy (Shavit, 2017) due, in a large part, to institutionalized health care system that does not allow individual to manage their own health care while incarcerated. CHWs are trained to assist individuals with health education, medication reconciliation and care management and to build capacity and empower clients to learn more about their own health care needs. They also assist people in navigating complex health services and act as advocates and cultural liaisons between clients and health care providers.

Population specific: People returning to the community from incarceration are sicker than the general population and all of their social determinants of health are in flux. They have a significantly higher prevalence of mental health and substance use disorders than the general population and return to medically and socially under-resourced communities such as the Bayview.

When developing the TCN program, Bayview community members and formerly incarcerated Southeast clients identified key components that would make a primary care based program for individuals returning from incarceration successful. Key components included: access to expedient and integrated behavioral health services; incorporating the program within existing community-based health centers rather than a siloed system; a focus on health and wellbeing and that services be provided by individuals who have knowledge and training regarding the physical and behavioral health impacts of incarceration.
Many behavioral health providers do not feel that they can adequately address the complex needs of individuals with systems-involvement and may refuse these client referrals.

By adding a full-time LCSW for TCN clients, the TCN program will be better equipped to adequately support and address client's mental health and substance use disorders. By employing an LCSW who is passionate about working with and trained in treating systems-involved individuals complex trauma and substance use disorder, clients who may have felt discriminated against or offered inappropriate treatment in the past, will be connected to the services they deserve.

By standardizing the behavioral health intake and service provision, TCN will seek to normalize behavioral health services, which can be highly stigmatized within communities of color and used against individuals in incarcerated settings.

The bi-monthly support groups will further sustain the wellbeing component of the program. Support

groups will be facilitated by an individual who has participated and facilitated peer-led support groups during their incarceration. Curricula will be based on evidence-based restorative justice principles with topics and logistics informed by client feedback. These groups will not only focus on healing and wellbeing, but facilitating social cohesion and support. By offering these groups in conjunction with other TCN services, it shows commitment to envisioning the program as imagined by the community we serve.
Securing employment is one of the most common goals identified by new Transitions Clinic clients. Many of TCN clients are newly released after many years of incarceration and are released with no resources. Our CHWs are able to successfully assist clients in securing employment placements, but several barriers still exist for our clients to start new jobs including: work specific clothing, tools, bus or subway fare, and basic technology support. These are barriers that can be addressed at the clinic-level with additional support.
Finally, by securing and convening a client advisory board made of current and past TCN clients, TCN will seek to assure that services offered and programmatic decisions at the clinic continue to be informed by individuals impacted by incarceration.

a. Describe your organization's policies, protocols, and trainings and how they ensure that staff deliver culturally competent programs and services.
The Transitions Clinic Network program is part of Southeast Health Center, a San Francisco Health Network clinic administered by the San Francisco Department of Public Health (SF DPH). The SF DPH is committed to developing and maintaining health services that are culturally competent, consumer-guided and community-based. Cultural competence is an essential requirement for health care providers to provide effective services to its diverse populations.

All SF DPH staff is required to participate in a variety of cultural competency trainings upon hire and have the opportunity to join optional trainings provided by SFDPH staff and the SF DPH– Behavioral Health Services Cultural Competency Unit is tasked with assuring that all clinics adhere to the National Culturally and Linguistically Appropriate Services Standards (CLAS). The SF DPH also has a robust set of policies and procedures in place to address issues related to cultural competency.

Transitions Clinic staff are highly trained and experienced in working with individuals returning from incarceration. Dr. Shira Shavit, the TCN physician has, for over a decade, worked exclusively with formerly incarcerated clients. The TCN CHWs, have personal experience with incarceration, and received special training in cultural competency and service provision through the Reentry Specialist Community Health Worker program at City College of San Francisco.

Additionally, in collaboration with formerly incarcerated colleagues, the TCN program developed a comprehensive 11-part interactive cultural humility training for health care staff that covers the following topics: mass incarceration; health, incarceration & reentry; facing stigma; needs, challenges & strengths; family reunification & relationships; impact of incarceration on health access & utilization;

exploring our assumptions & beliefs; role of formerly incarcerated staff in Transitions Clinic; community engagement and wellness; working with corrections and our role in advocacy and change. Exercises include a values clarification around working with people with a variety of incarceration histories. All new TCN staff are required to review and complete this online training.

8. Did the priority populations participate in the design of the proposed services? Yes

If so, how?

In 2005, two UCSF physicians joined with City College of San Francisco and the advocacy group Legal Services for Prisoners with Children to convene a meeting of formerly incarcerated individuals and community organizations to envision what a program to address the transitional and primary health-care needs of recently released individual returning to San Francisco from California state prisons should look like. The Post-Release Wellness Project, as it would later be called, conducted in-depth key informant interviews and focus groups with impacted community members, local community based organizations, formerly incarcerated clients and health workers with histories of incarceration. With this community input and support, the founding physicians established the Transitions Clinic Network (TCN) in January 2006 in collaboration with leaders at Southeast Health Center (Wang, 2010).

When developing the program, community members and formerly incarcerated clients identified key components that would make a primary care based program for individuals returning from incarceration successful. Key components included: access to expedient and integrated behavioral health services; incorporating the program within existing community-based health centers rather than a siloed system; a focus on health and wellbeing and that services be provided by individuals who have knowledge and training regarding the physical and behavioral health impacts of incarceration.

TCN clients and providers feel strongly that these needs should be addressed by non-mandated, community based service providers. The TCN at Southeast does not take funds from California Department of Corrections and Rehabilitation or any other prison system and does not report any information back to parole or probation without the clients' explicit request.

New services to be offered were designed by the TCN staff in response to client and CHW feedback about current gaps in the program.

The idea of implementing bi-monthly support groups came from TCN's CHWs with a history of incarceration who felt that they would further foster a sense of community and wellbeing. Support groups will be facilitated by an individual who has participated and facilitated peer-led support groups within prison. Curricula will be based on evidence-based restorative justice principles with topics and logistics informed by client feedback.

Securing employment is one of the most common goals identified by new Transitions Clinic clients, who have shared with CHWs that some of their primary barriers include: clothing, bus or BART fare, and basic technology skills.

Finally, by securing and convening a client advisory board made of current and past TCN clients, TCN will seek to assure that services offered and programmatic decisions at the clinic continue to be

informed by individuals impacted by incarceration.

9. In what ways will the priority populations be involved in the administration of the proposed services?
As formerly incarcerated community members themselves, TCN's CHW's not only provide an essential service by providing direct care to clients, their perspective is integral to programmatic decision, evaluation and objectives. TCN CHW's collaborate on grant and funding requests and are intricately involved in all aspects of program planning and administration.

TCN's Lead CHW will organize the support group, which will be led by a formerly incarcerated facilitator. Curricula topics and meeting logistics will be informed by TCN client focus groups and CAB members. This will allow TCN to draw upon the expertise of formerly incarcerated community members who have participated and led support groups within prison.

The TCN will reach out to other reentry providers and organizations to identify a qualified formerly incarcerated technology coach to assist clients with basic technology skills needed to navigate health care and reentry services. This coach will be responsible for tracking clients and outcomes.

TC CHW's will be included on the hiring panel for the LCSW, support group facilitators and technology coach.
The CAB, made up of former and current TCN clients, will meet quarterly to help inform programmatic decisions, program objectives and staffing and the TCN CHW will report feedback directly to TCN and Southeast clinic administration and staff.

10. Does your organization implement a whole person care approach, which considers the full spectrum of needs – medical, behavioral, socio-economic, etc. – of the priority population in a coordinated and integrated way? Yes
If so, how?
The TCN program is a primary care based intervention for individuals with chronic health conditions returning to the community from incarceration that takes a whole person care approach by addressing physical and behavioral health, wellbeing and the social determinants of health. One of the core tenants of the model of care, is that it's imperative to address both health and wellbeing among these clients. In order to do so, the program had to evolve and transform traditional primary care. All new TC clients have a 45 minute intake with the physician. They also create a holistic health and reentry care plan with CHWs. While management of physical and behavioral health needs are prioritized, all social determinant needs are assessed as well: housing, employment, family and social support, food security, etc. The multi-disciplinary TCN team assists clients in accessing care that is available onsite: medical, dental, (some) behavioral health, medication assisted treatment, Hepatitis C treatment, a food pantry and legal assistance. The CHWs also provide warm hand-offs to trusted reentry organizations in the community.

11. Does your organization collaborate or plan to collaborate with other partners in delivering services or promoting the well-being of the priority populations to achieve whole person care? Yes

If so, how?

The TCN is based within a Southeast Health Center, a primary care clinic. The multi-disciplinary team is able to address the acute and ongoing physical and behavioral health needs of clients. Southeast also offers all clients a weekly legal clinic, acupuncture, a pharmacist, onsite food pharmacy and nutritionist that TCN clients can utilize.

During intake, TCN's CHW's assess the social determinant of health needs of clients. This information is utilized to facilitate referrals to other organizations that are able to address those needs in conjunction with the TCN clinic and client.

Common needs are benefits enrollment, long-term housing, employment, vocational skills, recovery support, educational opportunities and food security. TCN CHW's have an outreach action plan that covers all domains of referrals and reputable local service providers. No one is referred to service provider until the CHW has vetted the organization: this means conducting a site visit; establishing a primary contact; understanding exactly what the agency can offer and assuring that the organization has been approved by the community served. The CHW's contact each provider regularly to see if staff or policies have changed.

The TCN program also collaborates with local and state advocacy organizations in order to advocate for policies that promote the health and wellbeing of our clients and the Bayview community at large.

12. Has your organization developed and/or adopted any trauma-informed policies? Yes

If so, please describe the policies and share how the policies have shaped your organization's practices. These could include policies related to hiring and onboarding, physical workspaces, staff supervision and support, staff education and training, client screening, client intake, or client treatment.

All San Francisco Department of Public Health staff, including the TCN care team, have completed the SFDPH's innovative Trauma Informed Systems 101 training. This training was developed by a group of experts throughout multiple systems invested in making the health care system more responsive to the needs of employees and clients with histories of trauma.

The trauma Informed Systems 101—Transforming Stress and Trauma: Fostering Wellness and Resilience is a foundational training for all SFDPH staff members. The training provides an overview to the six principles of trauma-informed systems and seeks to help staff share foundational knowledge of the impact of trauma on the people SFDPH serves, staff, colleagues, the health system and community and create a shared language which staff can used to respond to the impact. The training's learning objectives are: understand effects of chronic stress and trauma on our lives, our

brains and our bodies; learn how race and culture intersect with trauma to impact individual, organizational and community health; understand and apply principles of trauma-informed systems; and learn strategies to develop individual & organizational resilience in order to create and maintain more healthy, trauma-informed responses in workplace relationships.

TCN's policies and programs are also trauma-informed and intentionally designed to avoid recreating an environment that mimics prisons or is punitive in any way. For instance, we waive the 15-minute late policy for our clients because we understand that it's not only unrealistic to expect clients to always be able to navigate to our clinic on time due to barriers such as limited transportation and housing instability, but also because penalizing them for being late sets a punitive tone. We also adopt a harm reduction approach when counseling clients about topics such as substance use and sexual practices. We provide non-judgmental support regardless of their current health behaviors, and seek to help our clients minimize harms through practices such as using clean needles and condoms. We also work with our clients to help them set their own health goals, which make space for them to begin to re-empower themselves.

13. What are the goals of the proposal and how will these goals address the stated need/problem?
Services supported through this proposal will lead to the following desired impacts for individuals with chronic health conditions returning to the Bayview district of San Francisco from incarceration: 1) improve health status; 2) promote wellness; 3) support economic opportunities.
The TCN program proposes to add a full time licensed clinical social worker (LCSW) at Southeast Health Center. The LCSW will be dedicated to working exclusively with TCN clients and have specialization in complex trauma, substance use and the impacts of systems-involvement. The LCSW will meet all TCN clients to assess their behavioral health needs and determine how to best support them in achieving their behavioral health goals. The LCSW will regularly meet with the TCN care team to assure that client's care is aligned and their needs are being met. Having access to a skilled, culturally-attuned, mental health professional who's working in concert with the care team will improve client's physical and behavioral health outcomes. We anticipate that this will also increase stability in employment, improve interpersonal relationships and quality of life.
The medical discharge planner will connect people with chronic health conditions discharging San Quentin State Prison to San Francisco to the TCN care team. They will receive copies of their recent medical records, information about services offered and, if desired, an intake appointment. The CDCR does not currently provide any discharge planning. This service will assure that individuals returning to the Bayview know where and how to receive essential health services.
Creating a client advisory board to inform program policies, policy and program objectives will improve service provision, program engagement and, in turn, client and community health. A bi-weekly, peer-facilitated support group for TCN clients will promote social connectedness, engagement and healthy re-entry. A skilled formerly incarcerated facilitator will lead the group, but topics and curricula will be informed by focus groups and responsive to the needs of the group members. Creating a safe space where a client can feel supported, connect to others with shared

history, address barriers and acknowledge successes will improve wellbeing and promote a sense of belonging.
Finding gainful employment is a common self-identified goal for TCN clients and many clients are able to find employment very soon after release. While individuals are excited to get back to work, or have their first legitimate job, they return to the community with no funds to support start-up costs related to gaining or sustaining employment. Providing clothing and transportation vouchers to clients at the clinic who are seeking employment will help mitigate these barriers to looking for and starting a new job.
Many TCN clients have been out of the community for decades and don't know how to utilize basic technology. It is imperative that individuals gain knowledge of how to use a cell phone and learn basic computer skills. These skills are needed to gain employment, but also to assure that clients stay connected to the clinic and take care of their health care needs. Having a technology coach stationed at the clinic and that can travel out to clients in the community to provide 1:1 instruction to clients will help secure employment; create a sense of empowerment and mastery; and assure that TCN clients have the basic skills needed to successfully navigate reentry.

14. What are the expected outputs (e.g. number of people served) of the proposal?
We propose that 200 TCN clients will be referred for a behavioral health assessment with the TCN program LCSW and 100 will engage in ongoing services; participate in 1:1 technology training and receive clothing and transportation vouchers. We anticipate that 10 clients will attend the bi-weekly support groups sessions at any given time.

We will recruit ten current and former clients to serve on the client advisory board. The medical discharge planner will provide medical discharge services to 100 clients with chronic health conditions returning to San Francisco from San Quentin State Prison.

15. What are the expected outcomes (e.g. increased health status in populations served) for people served during the grant term?
The desired outcomes of the program are the following: 1) Improve the health status (physical and mental health) among chronically-ill individuals returning to the Bayview from incarceration 2) Support economic opportunities for chronically ill individuals returning to the Bayview from incarceration by improving technology skills and reducing barriers to employment 3) Promote wellness and social connectedness among individuals with chronic conditions returning to the Bayview from incarceration.

16. Describe how you will be able to demonstrate that your approach is being carried out as intended.
The TCN clinical team will work with the new LCSW to create a workflow to assure all clients are referred for a behavioral health intake. The team will also create policies and procedures around timeliness to access, general clinic flow, communication and documentation and frequency of case conferencing and team meetings. Service provision will be documented in the clinic's electronic health record. Clients will complete client satisfaction services on a bi-annual basis to assess their

whole TCN experience and provide feedback. The CAB will also be involved in aspects of program planning and service provision.

The medical discharge planner will track the number of referrals to San Francisco and the number of individuals who receive services at the TCN upon release.

Support groups will be based upon restorative justice principles and the TCN Lead CHW will work with the facilitator and client focus groups to find and adapt evidenced-based curricula that addresses the needs of TCN clients. There will be a log documenting theme and objectives of each focus group and a calendar outlining this to attendees. There will be an anonymous tracking log to document the number of individuals attending each group. If group attendance wanes, the TCN Lead CHW will work with facilitator and clients to identify factors that may be contributing to decreased attendance.
All clients will be assessed for employment eligibility and status by the TCN CHW upon intake and those who self-report that they are seeking or found employment will be offered a transportation and clothing voucher. This will be documented in the electronic health record and the voucher number will be tracked. Each client will only be eligible to receive each voucher once.
All clients will also be referred to the support group and Technology Coach by the CHW. The Technology Coach will track the number of clients they see weekly and come up with a basic skills assessment/checklist to cover with each client.

Evaluation Plan

1. What internal controls will be in place to reduce the risk of misuse of resources and to ensure accurate financial reporting?

The San Francisco Public Health Foundation has maintained internal controls for more than 10 years, the controls are audited and updated at least once a year during our annual audit by an independent audit firm. SF PHF internal controls include separation of duties, controlled access to sensitive documents and processes, audits, standardized forms and processes, monthly reconciliations of all financial accounts with multiple reviewers, and expense/check writing approval authority at higher amounts.

The Transitions Clinic Network has been operating as a grant funded- fiscally sponsored program since 2006 in collaboration with San Francisco Public Health Foundation (SF PHF). TCN has received individual grants ranging in size from $5,000 to $1.3 million and has participated in larger collaborative grants. TCN has a long track record of successfully implementing grants, meeting and exceeding deliverables and proven outcomes. All grant funds are expended in accordance with our funder and their regulations.

2. What procedures will be in place to ensure that the services will be implemented as planned? (Process evaluation)

The Transitions Clinic Network has been operating grant funded programs since 2006. Our largest program implementation was the 2012 Center for Medicare and Medicaid Innovation Health Care Innovation for $6.8 million dollars over 3 years that we received in collaboration with our partners at City College of San Francisco. Our organization was the lead entity on a large subcontract with 12 federally qualified health centers to implement the Transitions Clinic model across 6 states and Puerto Rico. We utilized a team-based approach that is led by the program manager, but allows for continuous communication and feedback by both the team members and the program participants. Our procedures are led by our program manager who creates a master project plan that sets goals, timelines, identifies team members and specific tasks, and frequency of team meetings to monitor progress and solicit feedback. These details are communicated in documents as well as clarified with team members to ensure understanding of their roles and tasks, program implementation can begin. Since this is a collaborative grant, our procedures dictate that this process will be completed with both teams (at TCN and SF DPH). Each team will have a team lead and meet independently on a weekly basis to check and monitor progress of service implementation. Team members will report status of both tasks and outputs (such as number of participants screened by mental health clinician, number of wellness group meetings, number of attendees of groups, number transportation vouchers given etc.) The program manager will coordinate project-wide monthly meetings between the two teams to ensure there is effective collaboration and communication across the teams. The program manager will be responsible to share client feedback and other data collected to iteratively inform and improve the project. Regular team meetings also include time to address barriers or challenges that staff faces

in program implementation and SF DPH and TCN leadership have open office hours for staff to solicit advice.

3. What procedures will you use to ensure you receive and use client feedback to inform decision making that leads to program improvement?
In order to ensure that we receive and use client feedback to inform decision making that leads to program improvement, we propose to create a client advisory board (CAB). This advisory board that will be made up of 10 clients will meet quarterly to 1) inform the development and 2) improvement of our clinical services. The CAB will be critical in developing the content of the wellness-group visits as well as important to recruiting new clients to participate in the services. We also will have the CAB give continuous feedback and review client participant surveys of clients who receive our services and give input to improve our services. We also will query our CAB related to how our organization can best address broader policies that impact our communities that may be acting as barriers to providing needed services to our clients. We will also engage our CAB in development of our evaluation, including client satisfaction surveys and pre/post evaluations of wellness group activities.

4. What is your plan for evaluating the effectiveness of your proposed services? (Outcome evaluation)
The desired outcomes of the program are the following: 1) improve the health status; 2) promote wellness and 3) support economic opportunities among individuals with chronic health conditions returning to the Bayview district from incarceration. To improve health status, we will hire one full-time licensed clinic social worker to work exclusively with TCN clients. Job description will specify that this individual have experience treating systems-involved individuals with complex trauma and those with substance use disorders. The LCSW will be trained in Eye Movement Desensitization and Reprocessing (EMDR) psychotherapy techniques that have been proven to improve post-traumatic stress disorder symptoms. All TCN clients will be referred to LCSW for initial assessment and work flows will be developed to assure that this assessment occurs. LCSW will document appointments in electronic health records and track the number of clients seen. Effectiveness will be evaluated through service utilization measured by electronic health record data abstraction, client satisfaction surveys and self-reported health status. To promote wellness, TCN staff will recruit and hire a skilled support group facilitator with a history of incarceration. Facilitator will work with Lead CHW, TCN clients and focus groups to adopt evidenced-based curricula to promote social support, social cohesion, accountability and a general sense of wellness. Effectiveness of support group in promoting wellness will be gauged by tracking client participation, number of outside referrals, client satisfaction surveys, client evaluations at the end of each group and self-reported health status. In implementing the support for economic opportunities, the TCN team will create tracking logs for clothing and transportation vouchers and work flows to assure that all clients seeking employment are offered these services upon. TCN will hire a technology coach who will develop a basic technology workshop to cover essential cellular phone and computer skills--they will develop a pre- and post-test for clients to gauge effectiveness of the programming. All new clients will be referred to technology

coach who will track referrals. Clients will also complete an evaluation of the services. Additionally, all new clients will complete a baseline survey that includes the social determinants of health as it relates specifically to employment. CHWs will identify and track via spreadsheets the need and resources provided to each client and the outcome of their employment annually during the proposed grant. Clients will complete a survey about the barriers to employment and the impact of the resources on maintaining their employment. The client advisory board will help inform what variables will be included on the client satisfaction survey for all aspects of service provision. The Program Assistant and Manager will be responsible for tracking all metrics and creating a cohesive report about outcomes related to these services.

a. What methods and key measurements will you use?

The desired outcomes of the program are the following: 1) improve the health status; 2) promote wellness and 3) support economic opportunities among individuals with chronic health conditions returning to the Bayview district from incarceration. We propose to evaluate 1) health statuses among our clients by having all new clients complete an initial baseline survey with the CHWs that includes a measure of self-reported health. This measure will be tracked annually during the course of the grant by the CHW. Additionally, all new clients will receive an initial mental health assessment by the LCSW and resulting referrals will be tracked through a spreadsheet. For clients who engage in direct mental health services with the LCSW service utilization (outpatient visits and acute care utilization such as emergency room visits and hospitalizations) will be measured through data abstraction from the electronic health record. In evaluating our 2nd goal, improving wellness among our clients, all the new clients will complete the validated 4-question CDC Health Related Quality of Life Tool (HRQOL) at baseline and then annually during the proposed grant. CHWs will track the participation in the wellness groups and mental health service utilization as outlined above will be extracted from the medical records. In evaluating 3) support for economic opportunities all new clients will complete a baseline survey that includes the social determinants of health as it relates specifically to employment. CHWs will identify and track via spreadsheets the need and resources provided to each client and the outcome of their employment annually during the proposed grant. Clients will complete a survey about the barriers to employment and the impact of the resources on maintaining their employment.

b. Who is/are the main individual/s responsible for the evaluation and describe their background?

Dr. Shira Shavit is responsible for the design and integrity of the evaluation. Dr. Shavit holds an appointment as Clinical Professor in the Department of Family and Community Medicine at the University of California in San Francisco (UCSF). She has extensive experience in program evaluation and research. The program manager, Anna Steiner, MPH is responsible for overseeing the evaluation implementation. Anna received her MPH at the University of California in Los Angeles and worked as program evaluator for the California Department of Public Health prior to joining the TCN. The CHWs at Southeast Health Center caring for the clients will be collecting the individual client level data through baseline surveys and annual survey also used for clinical service management.

c. How will the evaluator be involved in the design and implementation of the evaluation?
Dr. Shira Shavit is responsible for the design and integrity of the evaluation. Anna Steiner, MPH is responsible for overseeing the evaluation implementation. The initial evaluation design will be completed in the first 3 months of the grant. The design process will include iterative feedback from the client advisory board (CAB) on the outcomes measures, the survey instruments and the methods of data collection. Dr. Shavit will also ensure that appropriate protections are taken in data collection by getting institutional review board (IRB) approvals if needed and that data remains encrypted throughout the evaluation process. Anna Steiner will work with both the TCN and SF DPH team to then implement the evaluation with the goal of including evaluation as part of program development and implementation.

d. Describe how you will ensure that your evaluation is impartial and objective.
As the scope and budget of this project limits the scale of evaluation to participant self-report, data abstraction from the electronic medical records and baseline survey data. We plan to use validated surveys and data pulls from the eHR to ensure that the data is objective. One way we plan to address impartiality to include the CAB in the evaluation design and implementation plan. Other strategies we have used previously to more robustly evaluate our programs include a randomized control group and propensity matching (see attached studies) none of which are in the scope of this specific project and evaluation. Other limitations we face is that we are currently unable to link data from the California Department of Corrections to community-based Medicaid claims data and cannot easily have a control group for comparison. Also, Dr. Shavit who holds a faculty position at UCSF has published papers in peer-reviewed journals and has also been a reviewer for several peer-reviewed journals will be responsible for the design and integrity of the evaluation.

5. In what ways will the priority populations be involved in the evaluation of the proposed services?
The Client Advisory Board will be involved in 3 ways. First, the CAB will be involved in the initial evaluation and survey design and the implementation plan for the evaluation. Second, they will provide ongoing feedback about the program services throughout the course of the grant. Third, they will lead two annual needs assessments with community members and provide the results and their recommendations to the teams. The CHWs with lived experience of incarceration will also be involved the evaluation design and implementation. They will be collecting baseline and annual evaluation data.

6. What is the likelihood that the proposed services will be able to continue without additional CalCRG funding in future years? Why?
The Transitions Clinic Network has been providing services to individuals returning from prison at Southeast Health Center since 2006 and has successfully raised funds to ensure ongoing serves for many years to come. The specific services in this proposal fall into 2 categories 1) service enhancements to improve existing services provided and 2) resource provision to provide specific

resources to address barriers that clients face in achieving economic stability. In the first category, we hope to utilize these funds to demonstrate the need and define the specific post-release mental health services best utilized in the primary care setting. We hope to leverage this opportunity to address policy and funding locally to support this position permanently. In the second category, it is unlikely that the services would continue without CalCRG funding in future years. The reality is that individuals released from prison to San Francisco are set up to fail. They are given very little money upon release and don't have the funds they need to get to jobs (which may be located far from their housing) or pay for job related supplies (such as work boots and work specific clothing) that can have an impact on the job choices they have. As the cost of living climbs in San Francisco, this problem will only worsen.

Budget

Direct Costs
Personnel Classifications Amount: $448,175
Personnel Classifications & Description:
San Francisco Public Health Foundation (Lead Applicant) Personnel ($158,964)

Shira Shavit, MD, Executive Director (5% FTE) will review all protocols, monitor project timeline and activities, and oversee budget expenditures and reporting. She will supervise the Program Manager, Program Assistant and Lead CHW and help train LCSW. Total salary is $211,000 annually with a benefit rate of 44% @ .05 FTE x 24 months= $30,384.

Anna Steiner, MSW, MPH, Program Manager (20% FTE) will assist with program management, deliverables and reporting. She will also staff the weekly medical discharge program at San Quentin, assist with training mental health staff and supervise Program Assistant. Total salary is $80,000 annually with a benefit rate of 44% @ .2 FTE x 24 months = $46,080

Joseph Calderon, CHW, Lead Community Health Worker (25% FTE) will coordinate focus group, develop, implement and oversee group wellness activities, client advisory board, and program to reduce barriers to economic advancement. Total salary is $65,000 annually with a benefit rate of 32% @ .25 FTE x 24 months = $42,900

Rand Hale, Program Assistant (25% FTE) will assist Program Manager and CHW Lead and provide administrative support, assist with data reporting and evaluation. Total salary is $60,000 annually with a benefit rate of 32% @ .25 FTE @ 24 months = $39,600

San Francisco Public Health Department (Collaborating Agency) Personnel ($289,210.50):

TBD, Licensed Clinical Social Worker (1.0 FTE). LCSW will provide behavioral health assessments and ongoing services, as needed, to 200 TCN clients at Southeast Health Center throughout the grant period. Total salary is $107,115 annually with a benefit rate of 35% x 24 months = $289,210.50

Employee Training Amount: $1,389
Employee Training Description:
San Francisco Public Health Department ($1,389)

Eye Movement Desensitization and Reprocessing (EMDR) Training ($1389.50). EMDR is a evidence-based psychotherapy technique that accelerates the treatment of trauma. This interactional, standardized approach has been empirically tested in over 20 randomized controlled studies with trauma patients, and hundreds of published case reports evaluating a considerable range of

presenting complaints, including depression, anxiety, phobias, excessive grief, somatic conditions and addictions. The TCN LCSW will receive 24 hours of EMDR training to receive certification in this technique.

Equipment & Materials Amount: $7,931
Equipment & Materials Description:
San Francisco Public Health Foundation will purchase ($7,931 total):

Laptop computer and software ($2,000). One laptop computer package including Word Programs will be purchased. The computer will be used by the technology coach and clients getting technology training at the clinic and partner re-entry organizations.

Mi-Fi Hotspot ($171) will be used with the laptop for stable and consistent wi-fi connection at Southeast Clinic and at partner reentry organizations.

Mi-Fi monthly data plan for 2 years ($1,200). Support data costs to utilize mi-fi device with laptop for 2 years.

Wellness support group lead manuals ($160). Will be used to purchase evidenced-based curricula and support manuals for wellness support group facilitator and clinic.

Food for support groups and CAB meetings ($4,200). Will be used to provide nourishing, healthy snacks to clients attending bi-monthly support groups and quarterly client advisory board meetings. Many of our clients experience extreme food insecurity and this provides an opportunity for them to receive a healthy meal while participating in wellness activities. Allows for $75/meeting for 56 meetings over 2 years.

Supplies for technology coach and peer groups ($200). To be used to purchase notebooks, pens, markers, easels and supplies needed to aid client participation and support wellness support group and technology coaching objectives.

Other Direct Costs Amount: $103,000
Other Direct Costs Description:
San Francisco Public Health Foundation ($103,000):

Support group facilitator consultant ($15,000). Trained facilitator will help develop curricula, coordinate with Program Manager and Lead CHW, recruit and engage clients and keep tracking logs. Will lead bi-weekly support groups over 2 years (56 total).

Work clothing vouchers ($40,000). TCN clients do not have funds for start-up costs related to

securing and sustaining employment. The TCN program will provide a clothing voucher for 200 clients (we will not provide gift cards for establishments that provide liquor).

Transportation vouchers ($20,000). Transportation expenses create another barrier for TCN clients. Therefore, TCN will provide patients $100 pre-paid Clipper (bus) cards to be used to access the clinic and facilitate transportation to work.

Technology coach consultant ($20,000). Trained technology coach will help develop basic technology workshop and key objectives and provide 1:1 technology coaching to 100 clients at the clinic and partner reentry organizations. Technology coach will work closely with TCN staff, recruit and engage clients and keep participation logs.

Stipends for client advisory board participants ($8,000). Ten TCN client advisory board members to receive $250/year for actively participating in 7-quarterly CAB meetings and supporting TCN programming, evaluation and policy development.

Indirect Costs
Indirect Personnel Classifications Amount: $76,545
Indirect Personnel Classifications Description:
San Francisco Public Health Foundation (Lead Applicant) Indirect Personnel ($17,145)

Accounting Assistant (5% FTE). SF PHF's Accounting Assistant will manage contracts, processing payments and expenses and providing fiscal oversight for this grant. Total salary is $60,000 annually with a benefit rate of 32% @ .05 FTE x 24 months= $7,620.

Program Coordinator (5% FTE). SF PHF's Program Coordinator will be responsible for liaising with SF DPH Staff and assuring that contract deliverables are met and reported to SF PHF in a timely manner. Total salary is $75,000 annually with a benefit rate of 32% @ .05 FTE x 24 months= $9,525.

San Francisco Public Health Department (Collaborating Agency) Indirect Personnel ($59,400):

Senior Administrative Analyst (10% FTE). SF DPH's Administrative Analyst will manage contracts, hiring and onboarding new staff and assuring that clinic policies and procedures rare followed. Total salary is $115,000 annually with a benefit rate of 35% @ .10 FTE x 24 months= $31,050.

Health Program Coordinator (10% FTE). SF DPH's Health Program Coordinator will be responsible for liaising with SF PHF staff and assuring that contract deliverables are met and reported in a timely manner. Also assists with supervision of LCSW and CHW. Total salary is $105,000 annually with a benefit rate of 35% @ .10 FTE x 24 months= $28,350.

Other Indirect Cost Items Amount: $12,960
Other Indirect Cost Items Description:
San Francisco Public Health Foundation ($12,960)

Rent ($12,960). SF PHF pro-rated rent on office space, $540 @ 24 months.