HEALTH QUALITY PARTNERS
of Southern California

BLUE SHIELD OF CALIFORNIA FOUNDATION

Safety Net Integration: Primary Care and Behavioral Health Integration through Community Collaboration

SUMMARY OF OUTCOMES REPORT

PHASE III

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Health Quality Partners would like to thank the following Community Health Centers for their participation in Blue Shield of California Foundation's

Safety Net Integration: Primary Care and Behavioral Health Integration through Community Collaboration Initiative.

Family Health Centers

Imperial Beach Community Clinic

La Maestra Community Health Center

Neighborhood Healthcare

North Coastal Mental Health

North County Health Services

Union of Pan Asian Communities

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Safety Net Integration: Primary Care and Behavioral Health Integration Through Community Collaboration

Phase III Summary Report

INTRODUCTION

BACKGROUND

The purpose of this report is to summarize key findings and outcomes for **Phase III** of the *"Safety Net Integration 2014: Advancing Primary Care and Behavioral Health Integration through Community Collaboration"* project. All phases of this project were implemented and managed by Health Quality Partners (HQP) with funding by Blue Shield of California Foundation.

Health Quality Partners first received funding in 2014 from the **Blue Shield of California Foundation** through an initiative entitled, *"Safety Net Integration 2014: Advancing Primary Care and Behavioral Health Integration through Community Collaboration."* The grant program aimed to support communities engaged or seeking to engage in collaborative activities to improve systems-level primary care and behavioral health integration. The one-year project period began July 1, 2014, and Health Quality Partners (HQP) received a budget-neutral grant extension through August 31, 2015.

Phase I. As part of the first round of funding (Phase I), HQP implemented a **Shared Treatment Planning** (STP) model for patients being seen simultaneously at **North Coastal Mental Health** (a specialty mental health services clinic), and **North County Health Services** (a Federally Qualified Health Center or FQHC). As per the STP model, a designated lead at each agency scheduled time to talk by phone to share patient updates related to contact information, diagnoses, current medications, recent lab results, treatment challenges, and treatment plans, thereby allowing clinicians to reconcile crucial health record information and develop a coordinated treatment plan. The **Transition Visit Pilot** (TVP) was also implemented during Phase I. The TVP linked long-term patients at **UCSD Gifford Clinic**, a specialty outpatient mental health clinic, with one of the three participating FQHCs where they would receive primary care, therapy, and medication management: **Family Health Centers of San Diego, La Maestra Community Health Center,** and **San Diego Family Care.** This intentional linkage was designed to ensure that individuals who were ready to "graduate" their intensive mental health program were successfully transitioned to a health center for continued behavioral health and primary care. Separate evaluation reports developed in September 2015 describe the outcomes for these two Phase I pilots.

Phase II. Additional funding from Blue Shield California Foundation allowed HQP to build upon the successes of Phase I and initiate Phase II entitled, "*Safety Net Integration – Phase II: Advancing Primary Care and Behavioral Health Integration through Community Collaboration*." Phase II began in October 2015 and continued through December 2016.

During Phase II, the Shared Treatment Planning model was expanded to include an additional mental health/primary care pairing in the Central San Diego area: **Union of Pan Asian Communities** (a specialty behavioral health services clinic) and **La Maestra Community Health Centers** (a FQHC). HQP also expanded the project evaluation to collect additional data about health outcomes, and patient and provider satisfaction with the initiative. One of the key take-aways emerging from the first two years of this project was the importance of linking behavioral health patients to community resources to meet their greater social service needs (i.e., food, housing, transportation, employment). This take-away resulted in building a Social Determinants of Health component into Phase III of this project. A separate evaluation report developed in March 2017 describes additional Phase II outcomes.

Phase II – Key Take-Away!

Shared Treatment Planning illuminated the fact that many patients' health issues were complicated by poverty and lack of access to social services.

Clinicians realized they could help bridge this gap by linking patients to community resources.

This discovery initiated the inclusion of the Social Determinants of Health screening component into Phase III!

Phase III. In Phase III, HQP expanded the Shared Treatment Planning component and added a social determinants of health screening component to address the patient resource issues identified during Phase II. HQP subcontracted with three additional community health centers – **Imperial Beach Community Clinic** (IBCC), **Family Health Centers** (FHC), and **Neighborhood Healthcare** (NHC) – to screen patients presenting with behavioral health needs for social determinants of health (SDOH) and use that information to link patients to community resources. The mental health/primary care pairings established during Phases I and II continued with their shared treatment planning protocols. Phase III began in January 2017 and concluded March 31, 2018.

The remainder of this report presents and summarizes **Phase III** outcomes for the *"Safety Net Integration 2014: Advancing Primary Care and Behavioral Health Integration through Community Collaboration"* project. **Section I** presents key findings for the **Shared Treatment Planning**

component. **Section II** describes outcomes for the project's **Social Determinants of Health** component implemented during Phase III.

SECTION I: SHARED TREATMENT PLANNING

Methods

Two pairings of mental specialty health clinics and community health centers participated in the Phase III Shared Treatment Planning (STP) project: (1) Union of Pan Asian Communities and La Maestra Community Health Center, both located in Central San Diego County, and (2) North Coastal Mental Health and North County Health Services, both located in North San Diego County. An unforeseen extended leave of absence of key project personnel during Phase III, however, resulted in minimal project participation by the North San Diego County pairing. Therefore, outcomes reported in this section largely reflect STP activities conducted by the Central San Diego County pairing.

The first step toward Shared Treatment Planning was for providers to individually identify which patients were being seen at both paired agencies, which is necessitated by the lack of a shared EHR system. To generate an initial list of "shared patients," providers at the mental health clinic would ask patients were receiving services their primary care. If the participating in HQP's Shared from one of the CHCs patients were asked to provide Treatment Planning project, mental health clinic to confirm consent to allow staff from the patient was indeed "shared." with the CHC provider that the asked if they were willing to Once confirmed, patients were clinic providers/nurses then participate in the project. The the client cases they would reviewed the list and selected review prior to and during their STP phone calls. For the first STP calls, nurses prioritized the more complicated client cases for review, which initially resulted in spending more time preparing for and conducting the call. Over time, however, the time spent preparing for and conducting the calls decreased as clinicians became more efficient at the STP process *and* clients stabilized *and* less complex cases were added to the review list. Patient recruitment continued on a rolling basis for the duration of the project.

Barrier:
Presently, there is no direct method for systematically and efficiently identifying the total universe of "shared patients" across agencies.

STP call sessions were typically occurred monthly or other agreed upon intervals. During the shared treatment calls, clinicians collaboratively reviewed each case and documented any changes to the client's contact information, diagnosis or care plan, medication, or lab work. Any recommended follow-up activities for the patients were also noted. The clinicians then agreed on

how valuable they thought the session was in terms of time well-spent on a scale of 1 (unnecessary) to 5 (extremely valuable). One clinician (determined at the beginning of the review session) completed a ***Shared Treatment Form*** for each client case reviewed and submitted the forms monthly to HQP (see Appendix A).

Each clinician additionally resolved any discrepancies or changes discovered during the call and entered updates in both the patient's medical record/paper chart and the agency's Electronic Health Record (EHR). Clinicians also documented the number of minutes each needed to prepare for and conduct the case conference. These time records were also submitted to HQP monthly for tracking, reimbursement, and analysis.

Shared Treatment Planning Outcomes

Between January 2017 and March 2018 (i.e., Phase III)**,** clinicians conducted 14 STP calls. During these calls, clinicians collaboratively reviewed and discussed cases for 23 unduplicated patients. Calls regarding these 23 patients generated a total of 198 shared treatment forms, with clinicians conducting 8.6 case reviews per client, on average **(Table 1).** The total number of calls and case reviews completed across all three phases of the STP project are also presented. Over half (56%) of STP sessions and the majority of patient case reviews (75%) occurred during Phase III.

Table 1. Shared Treatment Planning Sessions

	Phase III	**All Phases (I, II & III) ***
	January 2017-March 2018	July 2014-March 2018
Number of Shared Treatment Planning Sessions	14	25
Number of Patients/Participants (unduplicated)	23	57
Number of Patient Case Reviews	198	269
Average Number of Case Reviews per Patient	8.6	4.7

*Includes STP activities conducted by both the North and Central San Diego County pairings.

Case Reviews & Updates

During each case review, clinicians documented any changes to the patient's contact information, diagnosis or treatment plan, medications, and lab results. Any recommended follow-up procedures or appointments were also noted.

During Phase III (as indicated above in **Table 1**), clinicians conducted a total of 198 client case reviews during 14 phone calls for 23 unduplicated patients. During these reviews, clinicians made a total of 269 changes to patient records, averaging 1.3 updates per client case review. Changes in type or dose of medications were most frequently updated (n=85), followed by lab results (n=72), client contact information (n=61), and the client's diagnosis or treatment plan (n=51).

Key Finding: The Shared Treatment Planning calls resulted in the identification and reconciliation of 269 extant discrepancies in patient records!

Table 2: Patient Updates (n=198 case reviews)

Phase III	Number of Updates	Percentage of Updates*
Medication	85	43%
Labs	72	36%
Client Contact Information	61	31%
Diagnosis or Care Plan	51	26%
Total	**269**	**136%**

***Total percent exceeds 100 as many client case reviews resulted in several changes.

Perceived Value of Shared Treatment Phone Calls

As documented in Phase I and Phase II project evaluation reports, clinicians and others participating in this project have expressed tremendous support for the Shared Treatment Planning model as an opportunity to improve patient care by updating prescription changes or reconciling duplicated medications/dosages. Additionally, efforts by mental health and primary care providers improved patient compliance with recommended follow-up visits by increasing dual levels of support and/or helping to resolve barriers to patient follow-up. Information gleaned during the calls also helped clinicians resolve and/or clarify with patients any misunderstandings about their diagnosis and treatment plans.

It used to be that patients with mental health issues would see their psychiatrist but would not go to their primary care doctor. This project has changed that because the mental health agency reinforces the importance of the client seeing their medical doctor and looking after their other medical needs. They don't get lost to follow-up as much.

~ NCHS Primary Care Provider

A patient came into our mental health facility and said he was diabetic. Our nurse was trying to determine whether the patient was testing his blood sugar and taking insulin or if he was being noncompliant. The North Coastal MH nurse talked to the NCHS nurse and found out the patient wasn't diabetic, but rather the doctor told him he needed to make changes to his diet to improve his health (and avoid possibly becoming diabetic). The nurses were able to explain to the patient what the real issue was.

~ North Coastal MH Program Director

The updates to the medication list were most valuable. Some medications cause metabolic problems, such as a higher risk for diabetes. I can monitor the psychotropic drugs the patients are taking and check for diabetes or lipid problems at the same time.

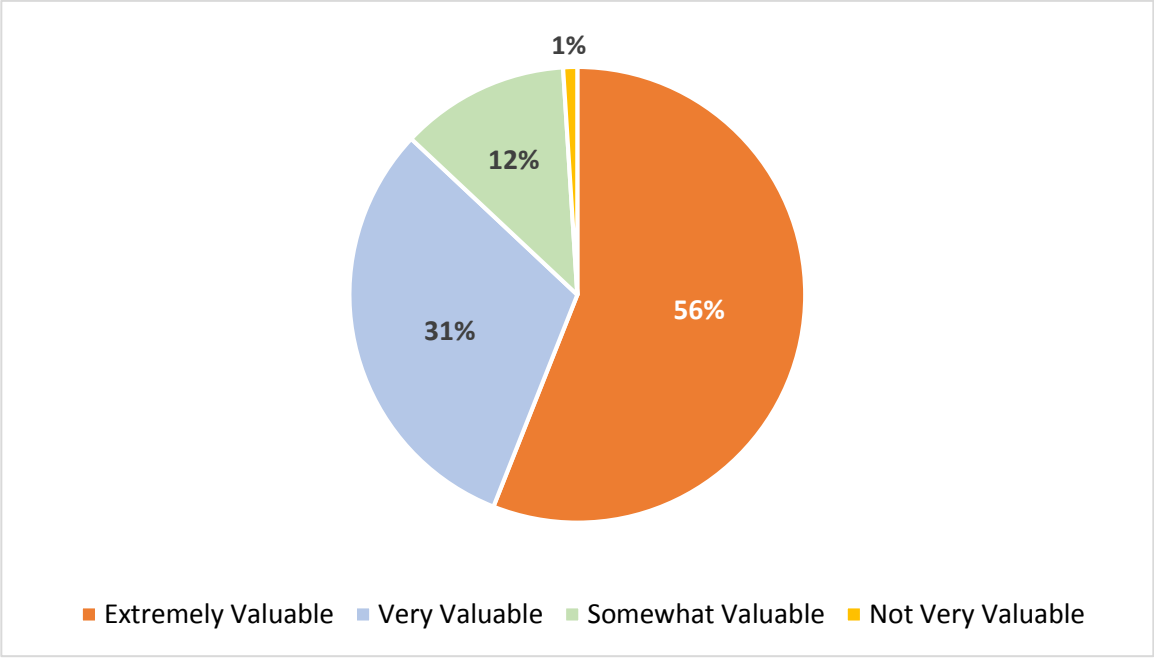
~ NCHS Primary Care Provider

North Coastal MH had a client that was not engaged in services with his PCP but was very engaged with them. North Coastal MH tried to find out what the barrier was and learned that the client did not have transportation to the medical clinic. NCHS was then able to send their van to pick up the client, and the problem was solved. It was an easy fix once the two agencies were able to confer.

~ North Coastal MH Provider

During Phase III, clinicians also were asked to rate the perceived value of each client case review on every Shared Treatment Form they completed. Clinicians recorded their perceived "value" for 188 of 198 patient case reviews conducted during their STP calls. Overall, clinicians rated 56% of client case reviews as "extremely valuable" and 31% as "very valuable." Clinicians rated 12% of client case reviews as "somewhat valuable" and only 1% as "not very valuable" **(Figure 1).** It is worth noting that as patients became stable their case reviews yielded fewer updates or treatment plan discrepancies, which may have affected the rating clinicians provided regarding their perceived value of the call.

Figure 1. Clinicians Perceived Value of Client Case Reviews

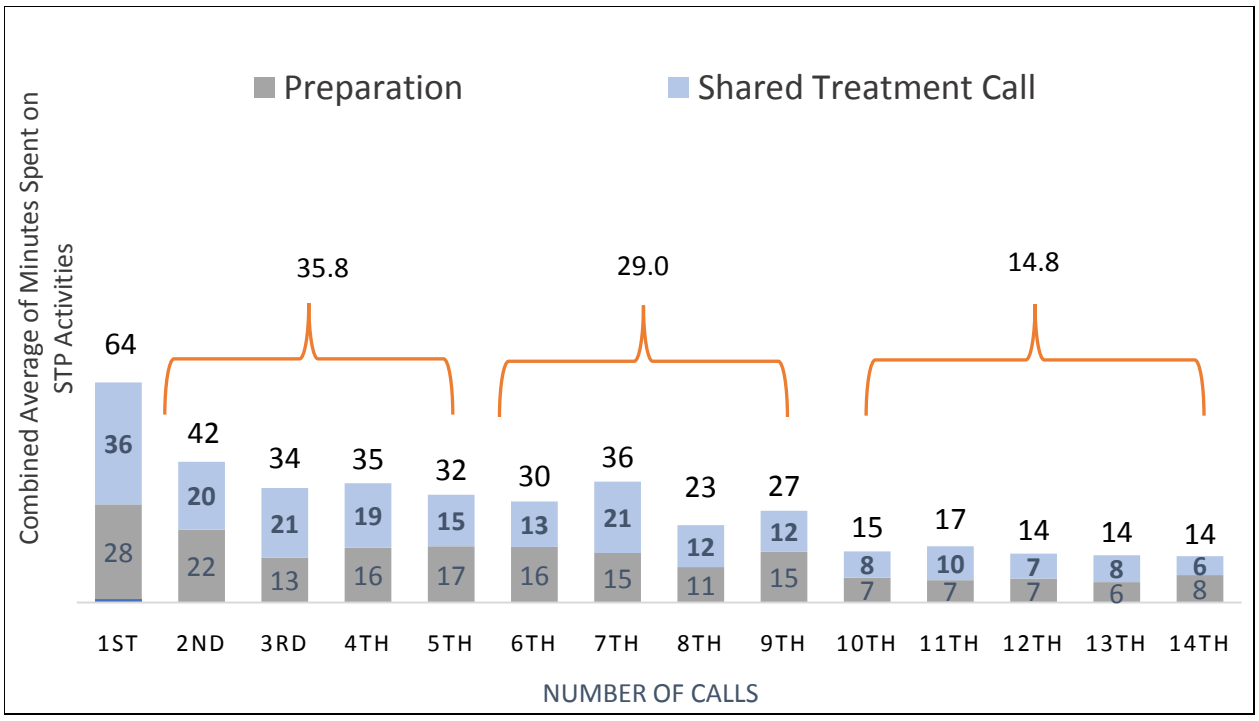


Time Study

While clinicians indicated that the knowledge they gained from STP calls was well worth the time they spent preparing for and conducting the calls, they also acknowledged that finding the time for integrating STP into their workflow can be challenging. Importantly, having an accurate assessment of the time required to implement and sustain STP is essential to the model's long-term sustainability within an organization. Therefore, as part of the project design, clinicians were asked to document the number of minutes each needed to prepare for and conduct the STP conference call. Each agency submitted these time records to HQP monthly, along with their Shared Treatment Forms. HQP developed a database to track the time staff invested in preparing for and conducting STP calls.

As illustrated in **Figure 2**, clinicians became increasingly efficient at executing the STP process within a short period of time. For the first STP call, it took clinicians a combined average of 64 minutes to prepare for and discuss all selected patient case reviews. Subsequently, for the 2nd through 5th sessions, it took clinicians an average of 35.8 minutes to execute the same protocol. For the 6th through 9th STP calls, clinicians required an average of 29 minutes to prepare for and conduct the reviews; and for the 10th through 14th calls, clinicians took only 14.8 minutes on average. It is also worth noting that the more complex client reviews were prioritized for discussion at the beginning of the project.

Figure 2. Average Number of Minutes Clinicians Spent Preparing for and Conducting Shared Treatment Planning Calls

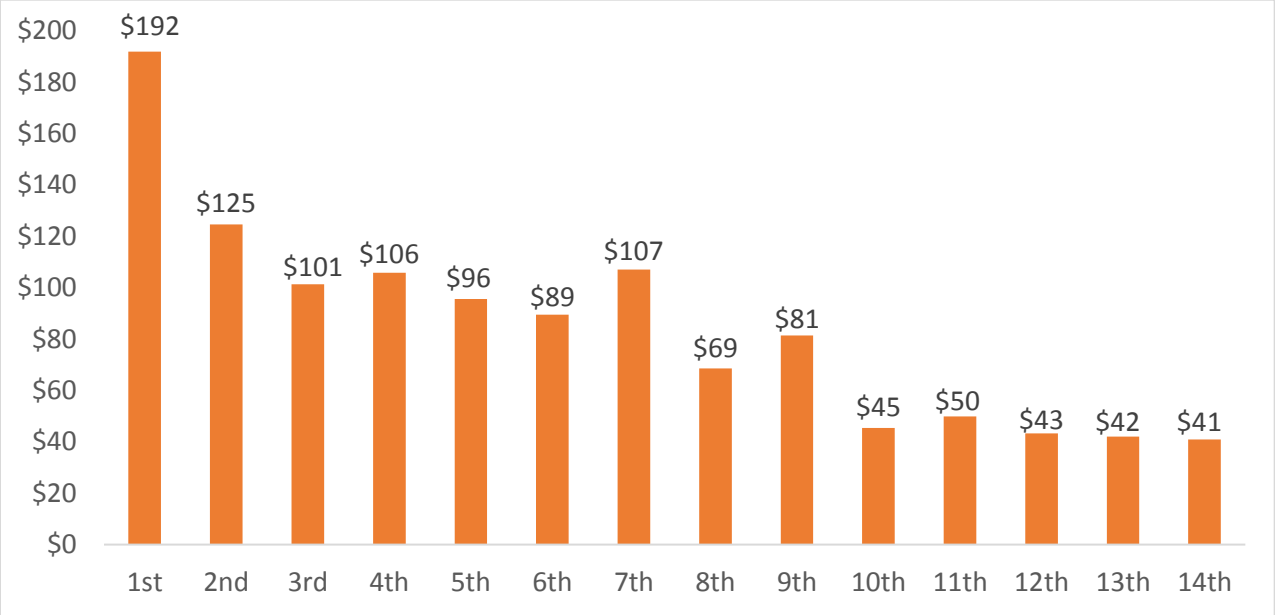


Cost Study

Cost is another important factor impacting sustainability of the Shared Treatment Planning work. For this project, costs were based on a reimbursement schedule of three dollars per minute. Total costs are determined by call frequency + time spent planning and conducting the calls. The frequency of case reviews per patient depends upon the complexity of the patient's case and treatment plan, such that stable patients require less frequent reviews than patients with more complex issues. At the same time, however, the more frequent reviews required to address and track complex patient issues may also reduce overall costs as a benefit of improved care coordination, increased patient engagement with health care, and reduced patient

symptomology that can result from the STP process. As illustrated in **Figure 3,** the average cost per patient trended downward, as clinicians became more efficient at the planning and review activities. Overall, total costs for all 14 STP calls during which 198 client case reviews for 23 unduplicated patients were conducted between La Maestra and UPAC during Phase III summed to $15,012.

Figure 3. Average Cost per Client Case Review Reimbursed at $3/Minute for Shared Treatment Planning Preparation and Call



SECTION II: SOCIAL DETERMINANTS OF HEALTH

During Phases I and II, clinicians engaged in Shared Treatment Planning (STP) began discussing various social services needs complicating their patients' health. They also began discussing various ways to meet those needs. The clinicians also discovered that both community health centers and specialty mental health clinics have access to a variety of in-house services and/or community resources to which they could refer patients and that, between them, they could often find a resource to assist their patients with some of the social services needs identified during their STP work. These clinicians shared their discoveries with HQP and sparked the development of an innovative social services protocol that HQP implemented as a key component of Phase III.

The Social Determinants of Health (SDOH) component utilized a care manager or other health center staff to screen patients who receive behavioral health and primary care services at participating health centers for SDOH and provide them with case management services. In preparation for this new project component, HQP facilitated a "Social Determinants of Health Roundtable and Resources Fair" to learn more about cross-system relationships and identify existing resource linkages between social services, primary care and behavioral health.

Social Determinants of Health Roundtable and Resources Fair

On November 11, 2017 Health Quality Partners held a three-hour SDOH Roundtable and Resources Fair for community partners. A total of 41 individuals representing nine Federally Qualified Health Centers and ten community social services agencies attended. The event's objectives were: 1) providing health centers with an opportunity to learn from each another about SDOH screening protocols; 2) teaching health center partners how to use screening outcomes to provide better care for their patients; and, 3) connecting health center staff with the community service agencies that could assist their patients in accessing the social services in need.

At the event's conclusion, participants were asked to complete an evaluation form rating various components of the Roundtable/ Resource Fair. Of the 34 evaluations submitted, 71% of attendees rated the overall event as "excellent" and 29% rated the event as "good." Roughly half of respondents (45%) indicated that they would use in their daily work what they had learned about the "expanded resource opportunities available through the community/clinics." Another 13% said they found it very useful to learn the "different ways agencies are successfully integrating tools for assessing SDOHs and tracking outcomes." Due to the resounding success of the Resource Fair, HQP is exploring options for offering an expanded version of this event again in 2018.

Social Determinants of Health Screening Methods and Limitations

For the SDOH component, HQP subcontracted with three health centers, **Imperial Beach Community Clinic** (IBCC), **Family Health Centers** (FHC), and **Neighborhood Healthcare** (NHC) to screen patients presenting with behavioral health needs for social determinants of health. Two of the health centers (IBCC and FHC) used the *"Protocol for Responding to and Assessing Patient Assets, Risks and Experiences"* (PRAPARE) tool for screening patients.[1] The third participating health center (NHC) used an internally-developed tool based on the Health Leads "*Social Needs Screening Toolkit*" (Appendix B).[2] This latter tool provides a menu of social services that clients

[1] Developed by National Association of Community Health Centers, Inc., Association of Asian Pacific Community Health Organizations, and Oregon Primary Care Association, 2016.

[2] https://healthleadsusa.org/wp-content/uploads/2016/07/Health-Leads-Screening-Toolkit-July-2016.pdf

can select if interested in receiving more information. Both tools can be administered either by a clinician as part of an interview or completed by the patient independently.

While there is some overlap between the two screening tools regarding the way questions were framed and/or available response options, there are also many differences which impede an aggregated analysis of results across health centers in some cases. For example, the PRAPARE screening tool combines several "basic needs" items into a single "yes" or "no" question box which often resulted in a single global response (i.e., "yes" or "no") rather than indicating "yes" or "no" for each basic need listed. In other cases, the types of SDOH asked about varied by tool. For example, the PRAPARE tool does not screen for substance abuse, while the tool NHC used does. Data codes and data entry methods also were not always systematic nor uniform across screening tools or even health centers using the same screening tool. Therefore, the number and type of patients' needs or SDOH are very likely underreported in this analysis and do not always directly correspond with the "goals" patients and their case workers selected to address.

Overall, NHC used their internally-developed tool to screen 213 patients at a single clinic site, while FHC screened 189 patients at nine clinic sites and IBCC screened 63 patients at two sites using the PRAPARE tool. Together, the three health centers screened a total of 465 individuals for Social Determinants of Health. SDOH data collected across health centers were submitted to HQP for compilation and analysis. Key findings from this analysis are presented in aggregate and highlight outcomes where data overlap and outcomes were mostly comparable.

Demographics

Just over half of patients screened (54%) were ages 46 and over; less than half (46%) were between ages 18-45 (**Figure 4**). Patients identifying as Caucasian accounted for 57% of patients screened. Persons identifying as Hispanic (20%), African-American (6%), and Asian (4%) accounted for a smaller proportion of patients screened (**Figure 5**). Neither tool includes a question asking patients to identify their gender.

Figure 4. Age

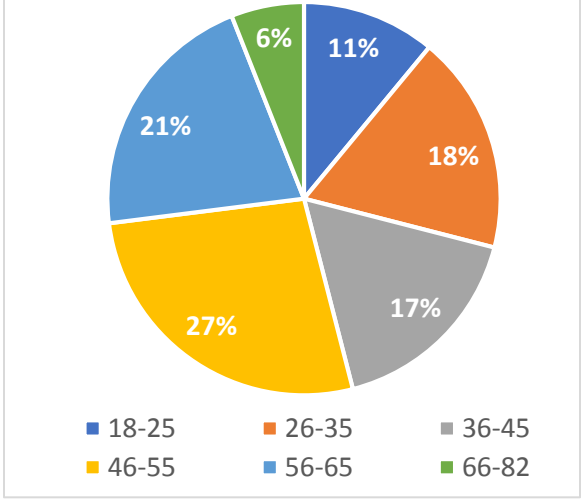
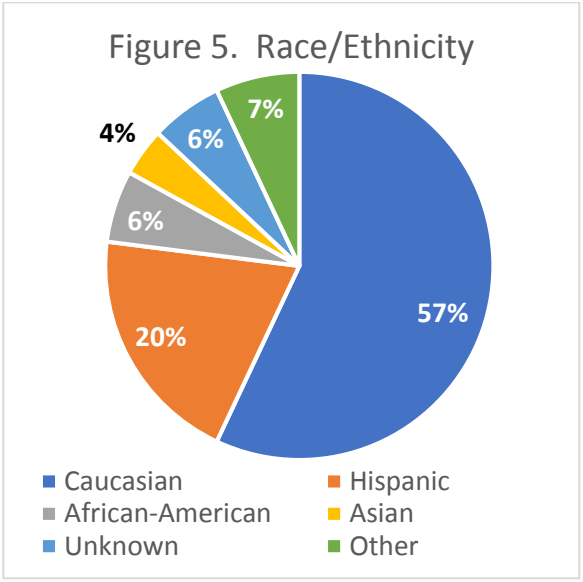


Figure 5. Race/Ethnicity



Social Determinants of Health Outcomes

Many patients indicated they suffered from financial and housing insecurity. For example, 78% said they were unemployed, 45% were worried about losing their current housing, and 38% identified as homeless or lacking stable housing. Not surprisingly, many patients also said they wanted assistance with "basic needs," such as food, clothing, utilities, or hygiene products (62%), and with finding stable or affordable housing (34%). Patients additionally said they needed a job (18%) or help applying for benefits or government assistance programs (18%), such as Cal Fresh, Section 8, or Medi-Cal. **Table 3** below presents the needs patients most frequently indicated during their SDOH screenings.

Table 3. Patient Identified Needs/Social Determinants of Health (N=465)

Type of Needs	Number	Percentage*
Basic (e.g., food, clothing, utilities, etc.)	289	62%
Housing (i.e., affordable or stable)	160	34%
Benefits/Financial Advocacy	85	18%
Employment	85	18%
Legal Aid	72	15%
Social Health (e.g., support groups)	68	15%
Transportation	65	14%

*Responses exceed 100% as respondents were directed to select "all that apply."

Following the SDOH screen, patients were asked to identify up to three needs that they wanted to prioritize and address with their case managers as "goals." Although housing was not the most frequently mentioned "need" (34%), affordable, secure or stable housing was the most frequently mentioned "goal" (43%), followed by employment (29%), benefits/financial advocacy (23%), basic needs (22%), and social health (21%) **(Table 4)**.

Table 4. Patient Identified Goals (N=465)

Selected Goals	Number	Percentage*
Housing (affordable or stable placement)	198	43%
Employment	133	29%
Benefits/Financial Advocacy	105	23%
Basic Needs	101	22%
Social Health	99	21%
Transportation	75	16%
Legal Aid	63	14%

*Responses exceed 100% as respondents were directed to select "all that apply."

After selecting goals, case managers worked to link their patients to applicable resources within the community. Case managers also were tasked with tracking outcomes and documenting the degree to which patients were successfully linked to the resources (i.e., "successfully connected," "appointment scheduled," "handouts/materials provided," "discussed," or "not addressed"). The way in which a "successful connection" was defined, however, often varied by agency, case manager, or by the type of SDOH. For example, in some cases, a "successful connection" meant providing a patient with a bus pass or bag of food; in the case of housing, a "successful connection" typically meant that a patient was referred to a housing assistance agency rather than obtaining affordable or stable housing. In descending order of success, **Table 5** displays how successful case managers were at connecting patients with their goal-related resources.

Table 5. Outcomes: Patient Linkages to Community Resources

Type/Number of SDOH Identified	Successfully Connected	Appointment Scheduled	Hand-Out Given	Discussed	Not Addressed
Basic Needs (n=101)	63%	8%	26%	3%	0%
Transportation (n=75)	63%	5%	13%	17%	2%
Housing (n=198)	41%	7%	44%	7%	1%
Legal Aid (n=63)	41%	14%	38%	6%	1%
Social Health (n=99)	36%	4%	46%	9%	5%
Benefits/Financial Advocacy (n=105)	35%	25%	33%	7%	0%
Employment (n=133)	31%	18%	40%	8%	3%

Key Project Take-Aways

Shared Treatment Planning

Implementation of a shared treatment model in which a behavioral health organization and a Federally Qualified Health Center conferred on their patients in common resulted in better care, even if that coordination was transparent to the patient. The providers ranked "overall client health improvement" as the top benefit of the project. As cited by clinicians during Phases I and II, the biggest challenges were tracking the care coordination objectives in the medical record and finding time to complete the Shared Treatment activities in addition to their other activities. In Phase III, when the majority of STP occurred, clinicians quickly became very efficient at the STP process and the time and costs required to conduct STP both decreased significantly. Nonetheless, moving toward adoption of health information exchange and encrypted email to streamline communication and reduce the burden on the workflow would help advance shared treatment planning to the next level. These investments would be worthwhile as a way of improving patient health and quality of life for a medically vulnerable population.

Social Determinants of Health

FQHC patients with behavioral health issues have numerous social service needs, and most have more than one. Some needs, such as access to food, are fairly easy to respond to and meet. Others, such as housing, are much more difficult to address and efforts in these areas often meet with limited success. Nonetheless, the opportunity for FQHC staff to find out how and where to access such resources for the patients in this pilot could end up benefitting patients with similar needs in the future.

Findings from this project component raise questions that warrant further research. Given the current thinking about the relationship between Social Determinants of Health and physical health/illnesses, devoting time and energy to determining which needs can be easily met, identifying resources for meeting those needs, and providing staff to do so, seem incredibly valuable and important. Additionally, future research in this area should include follow-up with patients who were linked to community resources to find out what happened as a result of the connection and how valuable they found the entire SDOH process –from screening to social linkages – as there may be a beneficial "snowball" effect that begins when providers demonstrate greater interest in and provide time for addressing the whole person.

Blue Shield Final Report Addendum

ATTACHMENT A: Shared Treatment Planning Session Update Form

Patient/Client number: _____ Date of Phone Call: _____
Form completed by: _____ Organization: _____

1. Which **joint treatment planning session** is this for this client (circle one)? 1st 2nd 3rd 4th 5th Other: _____

2. Did any of the patient/client's **contact information** change? □ Yes □ No
   If so what? _____

3. Was there a change in **diagnosis** or **care plan**? □ Yes □ No
   If so what? _____

4. Were there any **medication updates** (check all that apply)? □ Yes □ No
   If so what? _____

5. Were there any **lab updates**? □ Yes □ No
   If so what? _____

6. Will PC or MH be **following up with the on anything specific** as a result of this planning session? (For example: additional labs tests, social service referral) □ Yes □ No
   If so what? _____

7. How **valuable** was this joint treatment planning session? (Circle score)

1	2	3	4	5
Unnecessary	Not very valuable	Somewhat Valuable	Very Valuable	Extremely Valuable

8. In how many months should the **next review** take place (Circle one)?
   1 month 2 months 3 months 6 months 12 months Other: _____

9. Additional comments, if any;

_____

ATTACHMENT B: Neighborhood Healthcare's SDOH Screening Form

Welcome to Neighborhood Health Care. Please indicate if you would like information for any of the following services. If you have any questions about any of the listed services, please direct them to a member of our staff. **FOR IMMEDIATE ASSISTANCE, YOU MAY ALSO CALL 2-1-1 PROVIDE YOUR ZIPCODE AND THE 2-1-1 OPERATOR WILL PROVIDE YOU WITH THE RESOURCE INFORMATION IN YOUR AREA.**

• **Physical Health:** ○ Primary Care Provider ○ Urgent Care Clinic ○ Dental Clinic ○ Vision Care Center ○ Support Groups ○ Health & Wellness Groups ○ Exercise groups/classes	• **Occupation/Education:** ○ Employment program ○ Job readiness program ○ Adult education ○ Community college ○ Vocational/trade school
• **Mental Health:** ○ Psychiatrist (Med. Management) ○ Counselor/Therapist ○ Specialty mental health clinic ○ Intensive outpatient/day treatment ○ Inpatient Treatment ○ Crisis Centers ○ Support Groups & Self-Help ○ Clubhouse	• **Financial Advocacy/Benefits:** ○ Money Management class or group ○ Medi-Cal Enrollment Assistance ○ Medicare Enrollment Assistance ○ Affordable care/covered
• **Social Health:** ○ Case management ○ Socialization & Advocacy ○ Educational class/workshops ○ Faith based organizations ○ Volunteer opportunity ○ Family support groups ○ Parenting classes	• **Housing:** ○ Homeless shelter ○ Affordable Housing ○ Board and care ○ Skilled Nursing Facility ○ Independent Living Facility (ILF) ○ Senior housing
• **Substance Abuse:** ○ Outpatient services ○ Inpatient services ○ Self-help Recovery Groups ○ Sober living ○ Faith based ○ SMART recovery	• **Legal Aid:** ○ SSI application advocacy ○ Family law ○ Restraining order ○ Children & youth law ○ Tenant/landlord disputes ○ HIV/Aids law
• **Transportation:** ○ North County Transit District ○ ADA Ride ○ LIFT services ○ Manage care plan transportation	• **Basic Needs:** ○ Clothing ○ Hygiene products ○ Food ○ Showers ○ Phone