Glendora Community Hospital

PATIENT SAFETY EXCELLENCE AWARD™ 2016 healthgrades

COMMUNITY HEALTH NEEDS ASSESSMENT 2017

CONTENTS

2016 GLENDORA COMMUNITY HOSPITAL COMMUNITY HEALTH NEEDS ASSESSMENT

EXECUTIVE SUMMARY

The 2016 Glendora Community Hospital **(GCH)** Community Health Needs Assessment **(CHNA)** is GCH's first assessment since its conversion to nonprofit status at the end of 2015, and continues CHNA's ongoing reach into the community it serves to better understand and meet the needs of that community. This process has been developed on several fronts, with input from a variety of sources. This report meets the requirements of the Patient Protection and Affordable Care Act **(ACA)**, which requires nonprofit hospitals to conduct a Community Health Needs Assessment at least once every three years. As part of the CHNA, each hospital is required to collect input from designated individuals in the community, including public health experts, as well as members, representatives or leaders of low-income, minority, and medically underserved populations and individuals with chronic conditions.

This Community Health Needs Assessment was directed by Glendora Community Hospital to address needs for residents in the nearby area, accounting for nearly 80% of all discharges from the hospital in 2016. Additional data was extracted from various community and government sources which include areas outside of GCH's primary service area, but contribute a small portion of the hospital's utilization.

The CHNA process incorporates three major areas of study and analysis. These include:

- Quantitative Data Review and Analysis, in which data provided by numerous sources are reviewed, analyzed, and summarized. The salient conclusions drawn are reported. These processes concentrate on use rates, disease incidence, population ratios, and other numerically organized data. It should be noted that the variety of sources used include many definitions and time periods. Often data presented may not relate to the same time period or population as other presentations. Sources included the Los Angeles County Department of Health's (LADPH) *Key Indicators or Health* (KIH), LADPH's Epidemiology reports, US Census Bureau data, and other sources for area-specific data.
- Qualitative data in the form of written surveys. These are distributed by participating hospitals, and the responses consolidated into one report, so service-area-specific analysis was not possible. The results are largely interpreted to cross-check the

responses from the Key Informants involved via focus groups and phone interviews. The highly-detailed surveys also produced information about health status of the respondents, as well as their views on health needs in the overall area.

- Representatives of area health agencies, social service providers, and local government organizations (collectively, Key Informants) were invited to several focus group sessions to offer their opinions as to community health needs. Those Key Informants who could not make any of the sessions were interviewed by phone and their responses incorporated into the responses generated by the focus groups.

Each methodology generates useful data in different ways, and the conclusions drawn address each methodology as appropriate. It should be noted that there are three different service areas addressed in this analysis.

PRIMARY HEALTH ISSUES

Area-Wide Focus Group Consensus Issues

KEYGROUP has conducted and is continuing to conduct focus group surveys and individual phone interviews with representatives of area health agencies, social service providers, and local government organizations (collectively, **Key Informants**). Over 40 health needs were suggested by the Key Informants. Preliminary results of interviews indicate a predominance of several issues noted by independent respondents. Six of these issues were specific diseases or conditions that are indicators of poor health. They are listed below, with a short summary of their impact on community health.

- **Diabetes –** There are two primary types: Juvenile Onset (Type 1) diabetes, typically diagnosed in children, is a condition due to the body's inability to make enough insulin to manage digestion. It is best controlled with diet and weight management, although medication exists to control insulin levels. Adult Onset (Type 2) diabetes is most often a lifestyle disease, brought on by excess weight, lack of exercise and/or diet. It is also controllable with appropriate changes to diet, exercise regimens and other lifestyle choices.

- **Obesity -** As a contributor to diabetes, high blood pressure, cardiac problems and orthopedic issues, this was mentioned by several respondents. LADPH provides data on health status for eight Specific Plan Areas (SPAs) Glendora is in SPA 3 – San Gabriel Valley. SPA 3 rates for Obesity in 2013 were lower than both the county average for children, and within Los Angeles statistical norms for adults. Nonetheless, the fact that all age categories reported between 20% and 35% rates of overweight and obesity indicates a significant opportunity for improvement.

- **Mental Health -** Several respondents mentioned a limited supply of mental health services, as well as a historical lack of payment programs for mental health services. The sources of care for mental health issues are typically outpatient settings, but physical problems either caused by, or complications of, mental problems are a major factor in bringing clients to hospital Emergency Departments. Various laws have been passed in the past 25 years to improve mental health care, and provisions of the Affordable Care Act mandate mental health parity in payment and treatment, but the regulations to define that parity are not yet clear. It is expected that mental health services will improve as payors develop systems to reimburse providers for the services they offer, but treatment for chronic mental health issues is beyond the scope of most hospitals. The primary issue for

acute care providers is developing protocols for addressing mental health issues that present along with the acute medical problems that bring patients to the ED.

- **Access to Healthcare –** Passage of the Affordable Care Act has had a positive effect on the number of area residents who lack health insurance, but providers of care to low-income clients still report difficulty making referrals to specialists. In many areas, wait times for appointments for MediCal recipients are still longer than optimum.

- **Substance abuse –** This omnibus category includes alcoholism, addiction to numerous illegal substances, and inappropriate use of prescription medications. Most of the issues are chronic in nature, although the presenting symptoms in hospital EDs are usually acute medical crises, such as accidents, trauma, overdose, or injuries resulting from unwise actions while intoxicated. Much of the work on substance abuse is funded by mental health payors, since the addiction issues underlying the problems are considered mental-health related.

Additional Issues

In addition to the issues related to specific health conditions, focus group and survey respondents also identified community conditions that promote or exacerbate medical problems. The most frequently-mentioned issues are listed below, listed in order from highest to lowest priority.

- **Care Coordination** - This was expressed in several ways, including need for coordination within the hospital, working with step-down services (Skilled Nursing, Home Health), and work with social service agencies to coordinate home-based services. As population health management issues become more significant, coordination among providers will emerge as a more important definer of how health organizations provide care to their client populations.

- **Education (General & Health Related)** - Several respondents mentioned the educational level of many patients as an issue in getting compliance with physician instruction, as well as a contributor to unhealthy lifestyles. This issue also emerged as a recurring theme in discussions of health management for various area populations. Finally, the availability of insurance

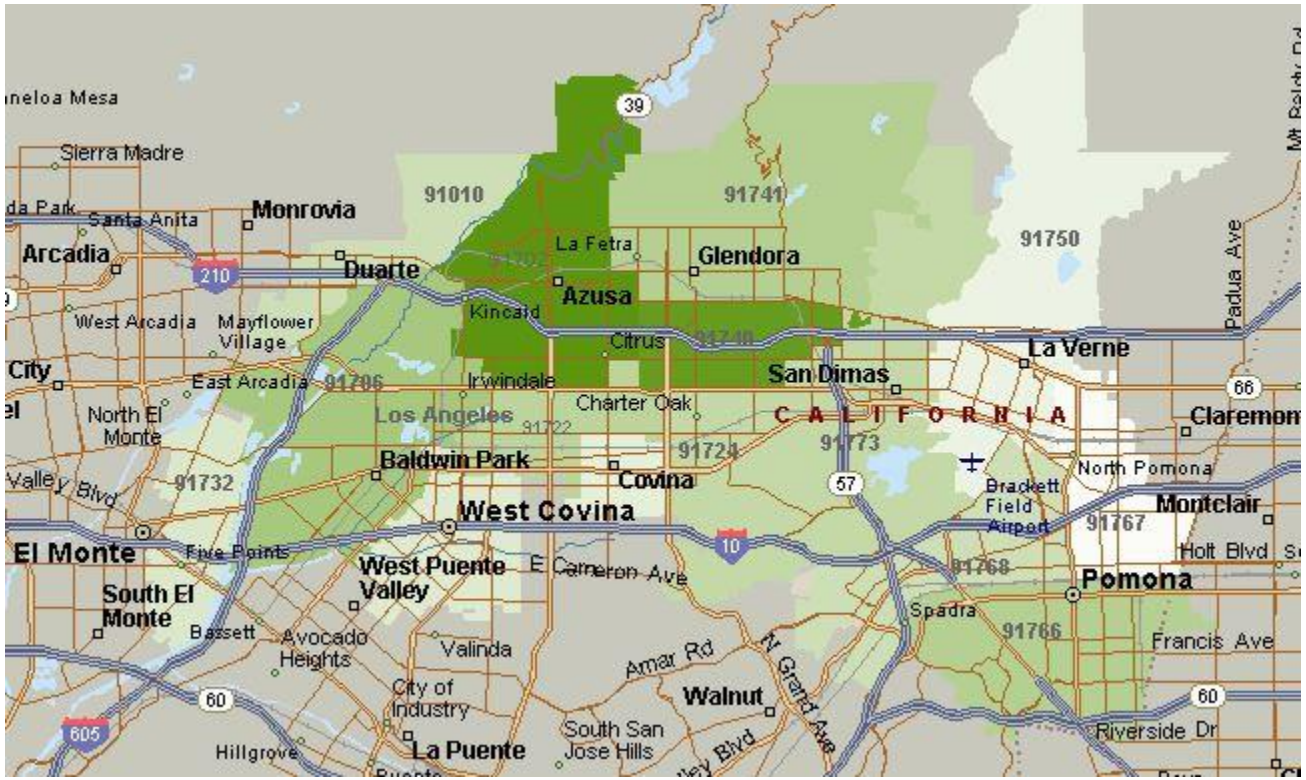
coverage for newly qualified individuals under ACA provisions has not been fully disseminated among many minority groups in the area. The result is that persons who would qualify for coverage have not learned about it, and thus may not seek services.

- **Diet** - This pertains to both diet choices made by local residents and availability of healthy foods in low-income areas. Some respondents mentioned that they considered portions of Montclair "food deserts" with limited availability of fresh fruits and vegetables, but ready access to fast food purveyors.

HOSPITAL AREA DEFINITIONS

Primary Service Area

The CHNA process involves analysis of several areas that are germane to the provision of services to the GCH "community". The most directly applicable is the area immediately surrounding the hospital: The cities of Azusa and Glendora account for 45% of all discharges, while surrounding cities (Baldwin Park, Covina, Duarte, Pomona, San Dimas and West Covina) six local zip codes account for another 34%. No zip codes outside of these cities contributed more than 1% of total discharges. The contributing zip codes are shown in the map below, with darkest areas representing the highest contributions.



Area-specific interviews were conducted with local care providers and service agency representatives. These updates are incorporated into the HASC study results and highlights of the additional research are noted where appropriate.

Glendora Hospital and Community Resources Action Plans to Address Needs - 2016

Resources currently exist in the community to address most of these priority needs, although in each case, more resources would be useful in combating the problems outlined. Resources and action plans for the needs identified are listed below, along with results from the implementation process.

1. **DIABETES (ADULT OBESITY)** – Diabetes was the single most-mentioned medical condition in virtually all interviews and focus groups. It was most often linked to obesity, both in adults and increasingly in children. Diabetes was also noted as one of the most treatable chronic conditions, with numerous potential interventions mentioned. Some interventions are already in progress, while others are in development stages. This condition is much more prevalent at GCH than many other chronic conditions. **Action Plan:** GCH is preparing to focus much of its education effort on the disease and its associated co-morbidities. The hospital is developing diabetes education programs to allow clients diagnosed with the illness to better manage their conditions. This program is also useful in reaching into the community and promoting weight management and diabetes control. It has significant potential to address a prominent community problem. **Result:** Diabetes education programs offered at the hospital are offered to hospital patients and the community at large.
2. **MENTAL HEALTH** – Mental health issues have historically been treated as less acute and treatable than physical ailments, and until recently payment for mental health services was less available than coverage for physical problems. Recent legislation has stressed the importance of mental health care, and health insurance policies meeting ACA standards must include mental health services as one of the required coverages. While the hospital is ill-equipped to provide long-term care for mental health issues, it is an appropriate platform for identification and referral to appropriate service providers. Developing greater capacity to triage and refer clients is an appropriate goal to pursue in improving the overall health of the community. **Action Plan:** GCH will explore services (particularly in emergency situations) which will contribute to a continuum of care for area residents exhibiting symptoms of mental distress. **Result:** GCH 's ED has developed protocols to deal with acute care issues with mental health comorbidities, and has expanded relations with local mental health providers to facilitate transitions out of the hospital and into appropriate stepdown environments. The hospital also has closely followed the changes in reimbursement for mental

health issues, and actively educates clients who present to the ED regarding availability of resources for continuing treatment once the acute issues have been resolved. The hospital is also actively recruiting for two more psychiatric positions to allow for more comprehensive coverage both at the ED and among patients admitted to the hospital.

3. **OBESITY** – While obesity was most often mentioned in conjunction with diabetes, it is a precursor to many conditions including stroke, cardiac disease, high blood pressure and many others. Providing diabetes education is one method of attacking the problem, but it is not the only way. Since obesity may be a factor in many presenting ailments at the hospital, it needs to be addressed in different ways to meet the needs of the presenting clients. This is a lifestyle issue, and while hospital staff can counsel clients in options to control weight, little direct intervention is possible during a hospital stay. **Action Plan:** The best option for the hospital is to promote healthy weight among its own staff members (the cafeteria already provides healthy dining options), and to work with community groups to promote healthy lifestyles. This is an area for additional exploration and development of educational programs. **Result:** As noted in the Diabetes discussion, the hospital is promoting healthy eating habits and food preparation with education programs both inside the hospital and in the community.

4. **ACCESS TO CARE** – The issues related to physician access were documented by both providers and patient advocates. Several specialties were listed as problematic, including nephrology, podiatry, and cardiology. While the hospital doesn't employ physicians, it has relationships with physicians in these specialties. **Action Plan:** GCH will explore options to make time available for specialists in these areas to see low-income and uninsured patients. **Result:** The hospital has analyzed physician needs within the community and is actively continuing to recruit to fill those needs. These additional physicians will represent another resource to support community health in non-hospital settings.

5. **SUSTANCE ABUSE** – The hospital does not provide direct services related to substance abuse beyond those described in the Mental Health section, but maintains referral networks to appropriate providers for clients who desire to resolve their substance abuse issues. **Action Plan:** GCH will continue to work with area providers to coordinate care for ED clients who need care for their substance abuse problems, and will continue to search for additional providers and methodologies oriented toward abuse issues. **Result:** Expanded capabilities for care of substance abuse clients.

6. **CARE COORDINATION** – The hospital currently maintains relations with local Skilled Nursing and Home Health agencies, as well as hospice services. These relations, typically coordinated by the hospital's director of case management, provide referral pathways to and from the hospital as patients' needs increase or decrease. The referral pathways typically are less well-defined once a patient is discharged to home. **Action Plan:** The hospital will contact and develop plans for better coordination among providers and social service agencies to assure that discharged patients can maintain themselves at home. This coordination effort can be beneficial both to patients and the hospital by reducing the incidence of readmissions within 30 days. **Result:** GCH has enlarged its roster of referral sources, and conducts regular interviews with providers in the area to assess their

capabilities and appropriateness for referrals. The hospital also regularly participates in community health fairs and clinics offered by other providers. GCH has also filed an application to contract with the Veterans Administration to serve veterans in the West End of Los Angeles County at its new clinic, scheduled to open January 2017. Planning is in process to develop a continuity clinic in conjunction with the hospital's Medical Director, which will provide an additional site for care.

7. **EDUCATION (GENERAL AND HEALTH-RELATED)** – The health education process should ideally begin in the community, and when patients are admitted, continue throughout the stay and provide resources to assist the patient in continuing his/her recovery at home. The hospital currently provides typical rehabilitation education, and information on medications administered while in the hospital. When patients need a continuing medication regimen to keep them from re-entering the hospital, data is provided to patients and their caregivers. In addition to inpatient education, the hospital provides community educators to meet with community groups and social services providers to educate the public on available educational and preventive care options available locally. The hospital also provides a substantial number of bilingual staff in areas throughout the facility to allow interaction with patients in their own languages. **Action Plan:** As more Asian clients use the hospital, staff will need to provide language- and custom-fluent attention to these patients. Outreach to agencies serving these groups will also be useful in designing programs to meet their needs. **Results:** The hospital has hired more bilingual employees and maintains a list of staff fluent in other languages. In addition, GCH has expanded its education outreach into local high schools to teach about cell phone safety, healthy eating habits and personal safety issues. Local health fairs and flu clinics are staffed by GCH providers, offering both education and preventive services. GCH participates in Chamber of Commerce activities promoting health and healthy activities.

8. **COMMUNITY CLINIC** – Existing community clinics coordinate care with the hospital. Additionally, Dr. Lally has privileges at both Montclair Community Hospital and at Chino Hospital. This relationship facilitates care coordination between the clinics and the hospitals. While the presence of a Medical Officer with relationships at several hospitals is a positive for the clinics involved, it does not completely resolve the issue of providing adequate physician coverage of all conditions encountered at the hospital, and opportunities exist to increase availability of specialist services and generalist physician coverage at the clinic. **Action Plan:** GCH plans to continue its support of services at area clinics, and to work with clinic staff to meet needs arising from services provided. As community needs for the clinic evolve with changes in insurance and access policies, the hospital will coordinate services to promote the clinic's continuing role in maintaining community health. **Results:** GCH 's support of outpatient clinics continues with medical staff services provided, and the hospital has developed and expanded a referral service to specialty providers to meet the needs of clients with specialty needs. The hospital also provides education to clinic clients about their eligibility for insurance programs that will cover needed care. The hospital is coordinating with the clinic to open a new continuity clinic site that will allow for expanded hours and services. Additional services provided through coordination with the clinic include flu shots, health screenings, and prenatal classes.

9. **HEALTH INFORMATION** – As was noted in the discussion of education, health information programs exist in the area, and hospital staff is diligent in providing discharging patients with protocols to assist them in continuing their recovery out of the hospital. Unfortunately, much of the information available is detailed and voluminous, and it is often difficult for patients to assimilate the information provided on discharge. There is opportunity to develop more understandable instructions for many conditions, and to provide referrals to successor agencies to continue the information transfer and coordination of care once the patient is back in the community. **Action Plan:** As mentioned in the discussion of Diabetes (see #4), programs will be expanded to assist clients in understanding their illnesses and managing their recovery, as well as in changing lifestyles to prevent future illnesses are in process for that illness, and the hospital will explore options to provide education regarding many other diseases. **Result:** Expanded diabetes education programs are in place, as well as programs to teach residents to shop and prepare meals using healthier ingredients.
10. **DIET (NUTRITION)** – **Action Plan:** Opportunities for addressing this problem range from educating residents on the hazards of their current diets, to advocating for more nutritious food options in local markets, sponsoring farmer's markets and lobbying local restaurants to provide healthy meal options. **Result:** The education programs mentioned earlier meet these needs.

ACKNOWLEDGMENTS

This CHNA 2016 is the result of the commitment and efforts of many individuals and organizations who contributed time, expertise and resource to create a comprehensive and effective community assessment. Special thanks go to the Steering Committee and the Advisory Committee members, the staff at Glendora Community Hospital, Community leaders and organizations that participated in our interviews and members of the community that took the survey and shared their experiences and information for the benefit of this assessment.

METHODOLOGY

Primary Data

This project concentrated its effort in gathering qualitative primary data through a series of contacts with key stakeholders that represent the community they are a part of, including government representatives, mayor, public health representatives, healthcare providers, service providers, realtors and minority group leaders. The tools utilized are summarized below.

Survey

A survey was disseminated to the community via the hospitals involved in the HASC report. Both English and Spanish versions were provided. The survey reached patients and community members of all ages and backgrounds. A copy of the surveys that were disseminated are listed in the Appendix at the end of this report.

All information was collected and analyzed, and a summary of results is discussed in the Key Findings Section of this report.

Focus Groups/Key Stakeholders Interviews

Extensive interviews with community leaders that would be able to address and further describe the needs of the community were conducted. A list of individuals and organizations is listed in the Appendix at the end of this report.

Representatives of City and County agencies included the staff of the Los Angeles County Department of Health, and the Los Angeles County 4th District Supervisor's Health Liaison, and the Director of the Los Angeles County Department of Public Health.

Secondary (Quantitative) Data

Available secondary data was used extensively to gather quantitative and qualitative information on the total service area, health and quality of life indicators, currently available services, evidence-based prevalence of diseases and conditions, and established adverse health factors at the community and County level. This data forms the basis for the HASC report, and is used here as a baseline for further analysis where PSA data was available for comparison. Where PSA-specific data was not found, the HASC report data is presented.

Secondary data also served as benchmarking tools to address needs priority, processes and outcomes. Including *Healthy People 2020* (Healthy People). Healthy People provides science-based, 10-year national objectives for improving the health of all Americans and has established nationally recognized benchmarks and progress monitoring. *Healthy People 2020* is the result of a multiyear process that reflects input from a diverse group of individuals and organizations.

Further benchmarking information was acquired from a variety of resources, including the U.S. Census Bureau, UDS Mapping, Community Commons, Healthy City, County Health Rankings & Roadmaps and Health Indicators Warehouse. Links to all these resources can be found in the Resources at the end of this report.

The County of Los Angeles's Departments of Public and Behavioral Health have embarked on a program called the Community Vital Signs Initiative, designed to develop county-wide information, analyzable in small local areas, which will allow healthcare providers of all sorts to create programs designed to improve the health status of area residents.

References/Secondary Data Sources

- 211 Los Angeles County. www.211SB.org
- Advancement Project. Healthy City. www.healthycity.org
- Advancing the Movement. Community Commons. www.chna.org
- Alzheimer's Association
- American Cancer Society
- American Heart Association
- American Lung Association
- California Department of Public Health
- Centers for Disease Control and Prevention
- Centers for Disease Control and Prevention. National Center for Health Statistics. Health Indicators Warehouse. www.healthindicators.gov
- Community Vital Signs. communityvitalsigns.org/portals/41/meetings/2013stakeholder/CVS_data_report.pdf
- Google Maps
- National Cancer Institute
- National Institute for Health
- National Institute for Mental Health
- Online KEYGROUP Survey. www.surveymonkey.com/s/NZZPCZF
- Prime Healthcare Services. Glendora Community Hospital. www.montclair-hospital.org
- U.S. Census Bureau
- U.S. Department of Health and Human Services. Healthy People 2020 Data. www.healthypeople.gov/2020/default.aspx
- University of Wisconsin Population Health Institute. County Health Rankings. www.countyhealthrankings.org
- World Health Organization, 2012