

Community Health Needs Implementation Plan 2017-2019



Sherman Oaks Hospital



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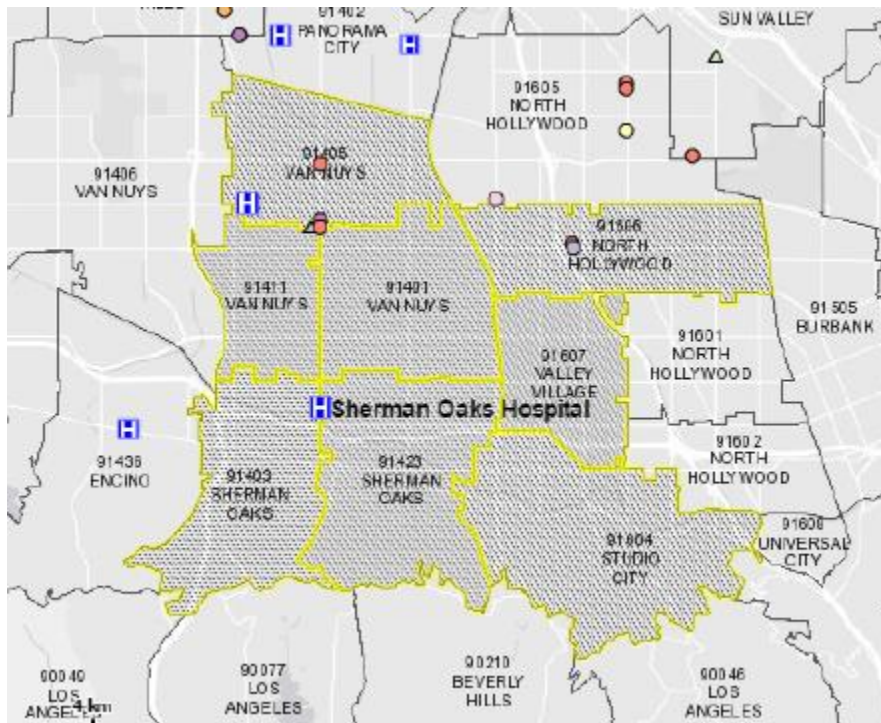
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SHERMAN OAKS HOSPITAL COMMUNITY HEALTH NEEDS IMPLEMENTATION PLAN 2017-2019

EXECUTIVE SUMMARY

The 2016 Sherman Oaks Hospital (SOH) Community Health Needs Implementation Plan (PLAN) addresses issues outlined in the hospital’s 2016 Community Health Needs Assessment (CHNA), and proposes actions to be taken to address those issues. The CHNA may be found on the Community Benefits page.

SOH’s PLAN focuses on the community immediately surrounding the hospital and concentrates specifically on issues that are within the hospital’s ability to address. Additional issues were raised by focus groups conducted throughout the San Fernando Valley by Valley Community Care Consortium (VCCC). Finally, SOH’s CHNA incorporates data from area-wide analyses provided by the Los Angeles County Department of Public Health (LADPH) *Strategic Plan 2013-2017 (Strategic Plan)*. LADPH divides the county into multiple Service Planning Areas (SPAs). Sherman Oaks Hospital is located in SPA 2, which encompasses the San Fernando Valley. The most important issues as determined by the groups are discussed in the following section, along with SOH’s plan to address those that are within the hospital’s ability to affect.



SOH’s Primary Service Area (PSA) is defined as the zip codes from which more than 50% of SOH’s discharges originate. A map of the PSA as defined by 50% of all discharges in 2014 is shown on the adjacent map.

PRIMARY ISSUES FROM SHERMAN OAKS HOSPITAL FOCUS GROUP SESSIONS – WITH IMPLEMENTATION PLANS

The SOH focus groups started with over 30 issues and the VCCC groups listed 29, but in both cases, the groups narrowed the range significantly, arriving at a top seven. The first two are closely related.

1. **Coordination of Care** – Existing payment programs and referral patterns among healthcare providers are highly site-specific, and patients leaving a hospital or other care provider are often also leaving the payment program that covered their care. Any follow-up care is often at the mercy of the entity to which the patient is referred, and often there is little or no coordination regarding care needs and/or regimens to assure maximum recovery. This can result in preventable relapses or complications. Over the past three years, the federal government has attempted to address these issues in many ways, but a true coordination system has yet to be developed. Individual providers are attempting to work across healthcare provider “silos” to organize care coordination programs, but much work remains to be done.

SOH’s plan includes working with stepdown providers, including nursing and rehabilitation hospitals, as well as home health agencies and social service agencies, to develop protocols to share information back and forth about clients transferred from one site to another, with provisions to assist other providers in maintaining health status of transferred clients as they continue their recovery. Additional research will be done to create methodologies for identifying high-utilization clients, and coordinating with social service providers to assist in supporting these clients in their homes so they don’t become admissions to the hospital.

2. **Transitions of Care** – The actual provision of care is just as fragmented as the payment system that supports it, and patients discharged from hospitals or other care facilities often find themselves at loose ends once they leave the premises. Care coordinators and social service agencies attempt to manage transitions, but their ability to assure appropriate care in offsite situations is constrained by their inability to actively follow clients from the facility to another care site or to home. Also, there are no formal programs to determine that the care settings into which patients are released are the most appropriate, or even adequate. Existing payment programs generally provide no ability to fund follow-up care or patient management programs. Some early systems are being designed to work with the most frequently seen clients to minimize the amount of time they spend in inpatient settings, but funding for such systems is not commonly available, and care providers are developing these systems on their own.

SOH’s Plan includes provisions to improve communications between the hospital and step-down providers both before and after transitions, to clarify client needs and necessary treatment protocols upon transfer, and follow-up communication within two days to review client status and address any issues that may have arisen following transfer. As payment

programs develop to facilitate such services, the hospital will work with providers to maintain an equitable reimbursement environment for all involved parties.

- 3. Payment Issues** – The Affordable Care Act has been very successful in increasing the number of California residents who have health insurance in some form, with one-third of the state’s residents now covered by MediCal. Fewer than 12% of the state’s total residents without insurance, down from over 16% three years ago. One side effect of the push to get people insured is that many of the insurance programs developed have been designed with substantial deductibles. So even though more people have insurance, they still face significant costs if they actually use that insurance. Thus, while the proportion of uninsured and self-pay patients decreased and the number of clients with insurance cards has grown, the amount of bad debt from unpaid deductibles and coinsurance has also increased. As insurance rates rise faster than inflation, employers who provide health insurance have increased their deductibles and copays as well. And while the ACA-conforming policies ostensibly cover a wide range of illnesses, including mental illness, the range of conditions not covered is still large. Finally, the election results and expected review of the ACA under the new administration will create new challenges and opportunities as the legislative and regulatory environment evolves.

SOH’s Plan includes provisions to continue assuring that clients who can get insurance coverage are directed to the appropriate sources. In addition, SOH will continue to review planned and newly passed legislation to ensure continuing affordability among clients.

- 4. Mental Health** - According to the primary data collected via key informant interviews, focus groups and surveys, many of the health care providers identified mental health as a major issue in the Sherman Oaks Hospital service area. Discharge records for 2014 from SOH show that the single most common MS-DRG family is Psychoses (the overall term for mental health issues), accounting for nearly 18% of all discharges for that year. Mental Health was the most commonly cited Health Need by VCCC focus group participants throughout SPA 2, and was also the fourth most-mentioned item, described as “Access to Mental Health Providers”. This condition is often a co-morbidity with other physical ailments, and mental issues existing beside actual physical disabilities complicate treatment for the physical manifestations. While mental health conditions are formally considered equivalent to physical ailments for payment purposes, diagnosis and treatment protocols for them are less well-defined, and most insurers tend to encourage outpatient care for all but the most dangerous mental conditions. Additional problems related to mental health include a high incidence of homelessness and substance abuse, which are not amenable to inpatient treatment and are typically not considered reimbursable services by payors. Since hospitals have no control over patients’ mental illness treatment courses after they are discharged, and compliance with treatment regimens is difficult, patients with mental issues in addition to their physical illnesses are some of the most often re-admitted clients at any hospital.

SOH’s Plan – As a primary care provider of mental health services, particularly in geriatric services, SOH is dedicated to continuing its existing services. As more focus is directed to mental health issues associated with acute admissions to hospitals, SOH is expanding its

coordination practices with community providers to identify high-intensity users of hospital services with accompanying mental health issues that can be addressed in alternative settings. With better coordination, these clients can be directed to more appropriate care sites. SOH will also research options to coordinate community care solutions with the hospital's inpatient services as crises arise in those community locations.

5. **Diabetes** – Diabetes was the physical ailment most commonly cited as an issue by the focus groups at SOH, and the second-most common Health Need cited by the VCCC focus group respondents. It is a common underlying condition for many other acute admissions to SOH and other hospitals because it presents so many complications that create crisis situations. While it is not one of the most common admission diagnoses, it is one of the most common complications accompanying the admitting diagnosis, and it was among the top ten causes of death cited in the Los Angeles Department of Public Health's *Strategic Plan*. Adult-onset diabetes is largely a lifestyle disease, commonly associated with obesity and lack of exercise. As with mental illness, treatment for diabetes is typically a long-term process and best conducted on an outpatient basis. But as is the case with mental illness, hospitals have little ability to control compliance with treatment regimens and thus, many diabetics find themselves in and out of hospitals as they fail to manage their condition. Diabetes was the second-most cited issue among respondents in VCCC's Focus Groups.

SOH's Plan is primarily focused on education, since care for acute diabetes issues is expensive and often delivered after the most effective treatments are available. SOH will continue to participate in health fairs, and coordinate with schools and community groups to educate area residents on the risks that lead to diabetes.

6. **Heart Disease** - Cardiovascular disease includes congestive heart failure, heart attack, coronary heart disease/coronary artery disease and stroke. Coronary issues are among the most frequently reported reasons for SOH hospital admissions, and these conditions are similar among other SPA 2 hospitals. Coronary Heart Disease and Stroke are the Number 1 and Number 2 causes of death in the *Strategic Plan*, and together they represent over half of all deaths due to the top ten causes of death in the county.

SOH's Plan includes education regarding stroke and cardiac risks, along with maintaining state-of-the-art services for cardiac emergencies seen at the hospital.

7. **Lack of Knowledge about Health Services** - Knowledge of healthcare needs is both commonly held and highly specialized. Nearly everyone knows that he/she should exercise, eat in moderation and not engage in risky activities. Beyond those basics, knowledge of specific behaviors and regimens to maintain good health is less common, and for people with specific health issues, the appropriate actions may not be intuitive. Added to this limited knowledge base is the fact that accessing experts (i.e., physicians, dieticians, etc.) can be costly for those not highly insured. Data is available on websites and various disease-related organizations work to inform the public about their chosen illnesses, but many area residents may not know where to find needed information, or may not feel they can afford to see the appropriate professional. During the primary data collection process, health care professionals and

service providers shared that there is a lack of knowledge regarding the existing health care services among their constituents. This lack of knowledge regarding low cost health care services makes it difficult for their clients to access the care they need.

SOH's Plan focuses on educational programs that target area residents who are not current clients of the hospital, delivered at health fairs, schools, retirement communities and other locations where people are interested in learning about health options. Additionally, the hospital staff maintains a database of insurance options that can be used to bring uninsured clients into the insured ranks, and works with eligible clients to get them covered. This is an ongoing process as insurance programs change often, and many more changes are possible over the next few years.

PRIMARY ISSUES RAISED BY FOCUS GROUPS IN SERVICE PLANNING AREA 2 AND SHERMAN OAKS HOSPITAL'S IMPLEMENTATION PLANS FOR THEM

The previous seven issues were raised by SOH's focus groups and listed as the primary issues for the SOH PSA. Additional data was obtained from VCCC's focus groups conducted at other locations. These interviews were conducted at various hospitals and other locations throughout the County of Los Angeles' Service Planning Area 2 (**SPA 2**). The SPA 2 Focus Group's top ten data also identified some additional issues that affect the greater San Fernando Valley area and residents of SOH's PSA. The issues not included in SOH's top seven are addressed below. SOH staff will work with hospitals and agencies throughout the Valley to address these issues as well as those specific to SOH.

8. **Obesity** – Although not a specific disease, obesity is a risk factor to other chronic diseases such as hypertension, high cholesterol, heart disease, and diabetes. It is most often addressed by lifestyle changes, but clinical interventions such as bariatric surgery are becoming more common. Unfortunately, the prevalence of obesity is also growing, making it a significant public health issue.

SOH's Plan incorporates education for children and adults about the hazards of obesity, and promotion of healthy eating and behavioral habits.

9. **Cancer** - Cancer is one of the leading causes of death in the U.S. Various types of cancer were three of the top ten causes of death in the *Strategic Plan 2017*. Cancers can occur in nearly every bodily system, and each type presents unique issues and treatment options. Since each type is tracked separately, the overall impact is understated by the three top causes in the top ten list. The fact that each type of cancer is unique also provides niches allowing hospitals and physicians to specialize in various treatments.

SOH's Plan focuses on triage for clients admitting with cancer symptoms, treatment for those symptoms easily treated, and referral to specialty hospitals for those with more serious problems, since SOH does not specialize in cancer care.

10. **Hypertension** – Hypertension is often grouped with heart disease, although it is a separate issue, related to constricted blood vessels that cause the heart to work harder to pump blood throughout the body. It is treatable with changes in diet, lifestyle, and if needed, drugs. **SOH's Plan** involves education and intervention in cases where the client is at the hospital, but the bulk of the education effort will be in outreach programs, coordinated with the senior services programs already in place at the hospital and delivered to sites in the community.
11. **Substance Abuse Disorder** – This category subsumes multiple “substances”, including alcohol, opiates, prescription drugs used off-label, and others, each of which has specific health problems associated with its use. The common factor is that the user does not or cannot control his/her consumption of the substance and thus is amenable to treatment. Each treatment course is unique to the specific problem, but all programs seek to wean the user from the drug and promote a lifestyle free from the abused product. **SOH's Plan** involves education and intervention in cases where the client is at the hospital, but the bulk of the education effort will be in outreach programs. The existing senior services programs are a useful base for identifying and treating substance abuse issues which are often presented as either acute trauma, or as contributors to a mental health crisis that admits to the Geriatric Psych program. Additional efforts are underway to identify service providers and continuing treatment locations to allow transfers of abuse victims to longer-term recovery programs that can follow up the treatment provided for the acute episode.
12. **Access to Primary Care** – Many of the visits to Emergency Departments result from illnesses or injuries that could be easily treated in a physician's office or clinic, if one were available. Since many area residents do not have a family physician, and many medical problems occur outside of normal office hours, the ED becomes the primary care provider, at great expense to the client and to the hospital. Provisions of the Affordable Care Act attempt to remedy this problem by getting more residents insured, and connected to a Primary Care Provider (PCP), but while more people have a physician to call, the office hours for most physicians are still limited, and the stock answer to a phone call to almost any physician's office includes a referral to the nearest emergency room if the call is of a critical nature, or if the office is closed at the time of the call. **SOH's Plan** - as noted in the Access to Care section of this plan, SOH will continue to attempt to find insurance coverage for all who present at the hospital's ED, and as part of that process will assist in finding a primary care provider affiliated with the coverage achieved. In addition, SOH's medical staff will reach out to local clinics to provide specialty care to clinic patients as appropriate.
13. **Poverty** – Like Obesity, poverty is not a specific disease, but its presence increases the odds that some ailment will occur. Poverty manifests as difficult lifestyle choices that put people in danger of medical crises such as diabetes, hypertension, and heart attacks, among other ailments. Areas with high poverty rates often have higher crime rates, and fewer sources of

healthy food, with an accompanying excess of less-healthy eating options. For the unemployed in poverty, the cost of health insurance is often unmanageable, and despite California's attempts to draw these residents into MediCal programs or other insurance options, the combination of difficulty getting qualified for benefits and the costs of obtaining care, are still high hurdles for many.

SOH's Plan – The hospital has no control over clients' incomes, and has no resources to augment incomes. However, as noted in the Access to Care section of this plan, SOH will continue to attempt to find insurance coverage for all who present at the hospital's ED, and as part of that process will assist in finding a primary care provider affiliated with the coverage achieved. Since clients with the lowest incomes are the ones most likely to qualify for MediCal coverage, this process should minimize the trouble clients have in seeking care. It should be noted that the results of the November 2016 election may cause Congress to alter some of the existing provisions of the ACA, and SOH staff will closely monitor any changes made and adjust their services to low-income residents to minimize any losses of coverage.

The issues above are the consensus issues from many sources that merit the most consideration by hospitals in the area. Each hospital has differing abilities to address each issue. As discussed above, Sherman Oaks Hospital's Implementation Plan will focus on the issues related to access and mental health.