Tarzana Treatment Centers, Inc

Community Health Needs Assessment

TTC Acute Psychiatric Hospital
SPA 2

Implementation Strategy

The implementation strategy for the Community Health Needs Assessment for TTC Acute Psychiatric Hospital primarily focuses on:

- Identification and prioritization of health needs
- Extent to which identified health needs are currently addressed
- Identified health needs the hospital plans to meet
- Identified health needs the hospital does not plan to meet
- Goals, objectives and indicators to meet health needs
- Specific resources to address health needs
- Impact of resources on health needs

I. Identified Health Needs and Prioritization

Tarzana Treatment Centers, Inc. (TTC) is a private, nonprofit community-based organization that operates a variety of behavioral healthcare programs and primary medical care clinics. Its 60-bed inpatient facility is licensed as an acute psychiatric hospital, and therefore, falls under the legislative umbrella of SB697. TTC prepared the 2012 Community Health Needs Assessment (CHNA) for its Acute Psychiatric Hospital in compliance with the Patient Protection and Affordable Care Act enacted on March 23, 2010, section 501(r) requirement on 501(c)(3) tax-exempt hospitals to conduct CHNA every three years. The objectives of this CHNA are to: 1) define the community we serve; 2) describe demographic, social, economic, health and other characteristics of the community/populations served; 3) describe the process and methods used to conduct the assessment; 4) assess the health needs perceived by providers, patients, and members of the community; 5) assess existing primary health care facilities and other resources within the community available to meet the identified community health needs; and 6) describe how individual providers collaborate to deliver services.

TTC's Acute Psychiatric Hospital is located in the city of Tarzana in Los Angeles County (LAC) in California. LAC has been divided it into eight service planning areas (SPA) based on geographic region for the purpose of the development and coordination of public health and medical services within the County. TTC's facility is located in SPA 2, which covers San Fernando Valley and Santa Clarita Valley. SPA2 served as the community of focus in preparing the CHNA.

The 2012 CHNA used the simplex prioritization approach to prioritize health needs by obtaining community perceptions via patient survey and key informant questionnaires. The responses to the questionnaires were calculated in percentages and were ranked, with the health issues with the highest scores given the highest priority.

Based on survey results, the top ten health priorities are:

1. Access to substance use disorder (SUD) programs and services
2. Tobacco control
3. Dental health
4. Infectious diseases
5. Health insurance
6. Violence prevention
7. Sexually Transmitted Infections (STI)
8. Mental health services
9. HIV/AIDS services
10. Child safety services

Based on the 18 Key Informant Interviews, the top nine health needs are:

1. Access to medical care
2. Mental health
3. Substance abuse disorder
4. Homelessness
5. Chronic disease management
6. Continuous care
7. Dental care
8. Obesity/weight management
9. Women's health

II. Extent to Which Identified Health Needs are Currently Addressed by TTC

The top health needs identified by community residents including patients of TTC's health care facilities and key informants including health professionals and representatives of local health-related agencies, community clinics, hospitals and behavioral treatment centers in SPA 2 community are consistent with the Healthy People 2020 Leading Health Indicators. Healthy People 2020 provides a comprehensive set of 10-year national goals and objectives for improving the health of all Americans. A smaller set of Healthy People 2020 objectives, called Leading Health Indicator (LHI), has been selected to communicate high-priority health issues and actions that can be taken to address them. These LHIs include: 1) access to health care; 2) clinical prevention services; 3) environmental quality; 4) injury and violence; 5) maternal, infant

and child health; 6) mental health; 7) nutrition, physical activity and obesity; 8) oral health; 9) reproductive and sexual health; 10) social determinants; 11) substance abuse; and 12) tobacco.

Co-occurring Substance Use Disorder (SUD) and Mental Health Disorder: Since TTC facility serves patients with co-occurring substance abuse and mental health disorders, it is appropriate to combine these two identified health needs. A significant clinical problem is the substance abuse needs of individuals with psychotic disorders. It is estimated that the lifetime prevalence of substance abuse among individuals with schizophrenia is about 50% with 20-65% having current substance abuse (Bennett, Bellack, & Gearon, 2001). In the Epidemiologic Catchment Area Study (Regier et al., 1990), the lifetime prevalence of any SUD was 16.7% in the general population whereas the rate was 56% among individuals with bipolar disorder. Patients with substance abuse and severe mental illness have a poorer and more difficult treatment course than patients with single disorders (Dixon, 1999). TTC provides mental health treatment services to patients who are diagnosed with co-occurring SUD and mental health disorder. In 2012, TTC served a total of 2,295 patients with co-occurring diagnosis (COD). The top 3 drugs of choice were heroin, alcohol and other opiates. Among all patients, 28% were injecting drug users (IDU). TTC will continue to provide existing services and will increase focus on continuity of care and discharge planning to ensure transition and linkage to next level of SUD treatment and/or mental health and primary medical care when appropriate.

Tobacco Control: Approximately, 85% of co-occurring diagnosis patients use cigarettes. TTC will routinely screen for tobacco use and referrals to 1-800-No-BUTTS hotline. When appropriate, staff will provide brief intervention based on 3A model of Ask, Advise and Refer.

Infectious Diseases (i.e., TB, hepatitis, measles, etc.): TTC will routinely screen and provide rapid testing for hepatitis and continue to provide referrals for treatment to community partner agencies.

Health Insurance: Based on TTC data, 57% of patients served by the Inpatient Facility were uninsured. Among the uninsured (n=1301), 25% were covered by Medi-Cal and 75% by LAC Healthy Way LA and LAC Substance Abuse and Prevention Control (SAPC). According to the Valley Care Community Consortium report, adult residents in SPA 2 identified the need for affordable and portable health insurance. The Affordable Care Act provides the opportunity to significantly reduce the uninsured individuals and to transform the health insurance marketplace. Eligible uninsured individuals will have health care coverage options and will be able to enroll into coverage. It is anticipated that ACA will provide affordable health insurance while assuring quality and access. TTC will implement routine benefits screening upon intake/admission and when appropriate provide benefits application assistance to eligible patients

HIV/AIDS Services: TTC will continue to provide co-occurring substance use disorder and mental health disorder treatment to patients who are HIV positive. It will also implement routine HIV screening and testing for individuals identified at high risk and will provide HIV/AIDS medical treatment at TTC's HIV/AIDS specialty clinic for those eligible

Dental Health: TTC does not provide dental health services to patients but does offer referrals when appropriate.

Violence Prevention: TTC does not specifically address violence prevention. TTC will continue to collaborate with community partner agencies in programs and initiatives that seek to prevent violence but does not anticipate initiating such a program in the psychiatric hospital.

Sexually Transmitted Infections (STI): TTC will continue to provide referrals to STI screening, testing and treatment when appropriate.

Access to Medical Care: This health priority is associated with Health Insurance which focuses on providing routine benefits screening upon intake/admission and health insurance application assistance to those who are eligible.

Child Safety Services: TTC will continue to collaborate with community a partner agency whose focus is child safety services but does not anticipate initiating such a program.

Chronic Disease Management: This health need is associated with Access to Medical Care priority need. Through TTC's proposed focus on screening for and linking patients to medical care, it is expected that the needs of those with chronic diseases will more likely be addressed.

Homelessness: TTC will continue to collaborate with community partner agencies in programs and initiatives that seek to prevent homelessness but will not initiate such a program. Additionally, the facility will continue to refer patients to available emergency shelter, transitional, supportive and permanent housing services including those provided by TTC.

Continuous Care: This health priority is associated with Access to Medical Care, Chronic Disease Management and SUD which TTC plans to address.

Obesity/Weight Management: TTC will continue to provide referrals when appropriate for obesity/weight management services. TTC currently lacks financial and staffing resources to provide such services in the facility.

Women's Health : TTC will continue to collaborate with community partner agencies with a focus on women's health issues and continue to serve women already accessing psychiatric hospital services.

Education and Prevention: TTC will seek to implement group education and prevention programs that address high incidence of tobacco use, STI and HIV/AIDS among patient population. Patients identified at risk will be given education and prevention information and when appropriate referred for screening, testing and treatment services.

III. Health Needs TTC Plans to Meet

In summary and based on the ranking of health needs identified by survey participants and key informants, TTC will address the following top 5 health needs for SPA 2:

1. Substance Use Disorder/Mental Health Disorder
2. Tobacco Control
3. Infectious Diseases (i.e., TB, hepatitis, measles, etc.)
4. Health Insurance
5. HIV/AIDS Services

IV. Health Needs TTC Does Not Intend to Meet

The other identified health needs including dental health, violence prevention, child safety services, homelessness, chronic disease management, continuous care, education and prevention, obesity/weight management and women's will not be addressed by the inpatient facility. TTC currently lacks financial and staff resources to provide services to address such needs. However, TTC will continue to collaborate with community partner agencies by providing referrals to help patients meet their other health needs. The rationale for not planning to address other identified health priorities are discussed in part in Section II above.

V. Goals, Objectives and Indicators in Meeting Health Needs

The implementation strategy described below will be integrated into TTC's Strategic Plan which is updated annually. The following table defines the goals, objectives and indicators in meeting health needs using a logistic approach. The goal for each health need is translated to objectives allowing TTC to define the activities that will be implemented. Whether the goal is being achieved or not will be explained by the indicators or measures for each objective.

Health Need: Co-occurring Substance Use and Mental Health Disorders		
Goals	Objectives	Indicators
Improved physical and mental health conditions of COD individuals in the community	To continue providing integrated substance abuse and mental health treatment	COD patients served Demographics of COD patients served
	To monitor treatment outcomes	Completion rate Dropout rate
	To determine effectiveness of COD treatment	Perceptions of COD patients toward treatment received
	To provide referral for social and support services post treatment completion	Number of referrals provided to each COD patient
	To determine relapse rate of COD patients	Number of COD patients that were readmitted
Improved smoking behavior of patients	To screen patients on tobacco use	Number of patients screened
	To refer patients to 1-800 NO-BUTTS hotline	Number of patients referred
	To conduct brief intervention on tobacco cessation for patients who are willing to address tobacco use	Number of patients that received intervention services

Prevention and treatment of infectious diseases	To implement screening and rapid testing hepatitis	Number of patients screened
		Number of patients tested
Improved access to health benefits	To provide referrals for treatment to community partner agencies	Number of referrals
	To conduct benefits screening at intake/admission	Number of patients screened
	To assist eligible patients benefits application assistance	Number of eligible patients that received application assistance
Improved access to HIV/AIDS services	To conduct HIV screening and testing for patients identified at high risk	Number of patients screened and tested
	To provide medical treatment for those tested positive for HIV.	Number of eligible patients referred to treatment

VI. Specific Resources Addressing Health Needs

The specific resources that the facility plans to commit include: a) financial resources; b) staff; and c) logistic resources. The financial resources will used for operating expenses which include, but not limited to: a) salaries, wages and employee benefits; b) contract services; c) medical and office supplies; e) rent and utilities; and f) information technology. The existing facility staff composed of the following will address identified health needs: 1 Full-Time Equivalent (FTE) Physician; 1 FTE Physician Assistant; 5.5 FTEs Clinical Psychologist/Psychiatrist; 11 FTEs LVNs; 4 FTEs RNs; 6 Per Diem LVNs; 8 Per Diems RNs; and 22 FTEs substance abuse counselors. The facility staff will be trained to help them perform their job responsibilities effectively, and thus, ensuring meeting health needs of patients. In addition, the staff will exert efforts to collaborate with TTC's partner agencies in referring patients for health needs not currently being addressed by TTC. The logistic resources will involve TTC management monitoring and overseeing the utilization of resources to ensure greater impact on the health needs.

VII. Anticipated Impact of the Resources on Health Needs

The table below illustrates how the resources will impact the health needs as indicated by anticipated outcomes. The outcomes determine the effectiveness of resources utilization in terms of whether addressing the health needs is meeting the set goals and objectives.

Resources	Health Needs	Outcomes
Financial resources Inpatient Facility staff	Co-occurring Substance Disorder and Mental Health Disorder	Number of COD patients served At least 75% of COD patients will have completed treatment at the end of every year

Logistic resources		No more than 20% will have left treatment against medical advice at the end of every year At least 75% of COD patients will have reported improved physical and mental health condition at the end of every year At least 75% of COD patients will have reported satisfied/very satisfied with treatment received at the end of every year 100% of COD patients will have received referrals for social and support services available in the community at the end of every year
	Tobacco Control	100% of patients will have been screened by the end of every year
		75% of patients will have been referred to 1-800 No-BUTTS hotline at the end of every year
		100% of patients that are willing to quit will have received intervention services on tobacco cessation at the end of every year
	Infectious Diseases	75% of patients will have been screened for hepatitis infection at the end of every year
		100% of at-risk patients for hepatitis will have been tested at the end of every year
		80% of patients that tested positive for hepatitis infection will be referred to treatment at the every year
	Health Insurance	100% of patients will have been screened for health benefits assistance at the end of every year
		100%of patients eligible for health benefits will have received assistance for benefits application at the end of every year
	HIV/AIDS Services	100% of patients will have been screened and tested at the end of every year
		100% of patients tested positive will have been referred to treatment at the end of every year

VIII. Collaboration with Community Partner Agencies

As discussed earlier, TTC will collaborate with community partners for health needs that will be addressed as well as those health needs that will not be addressed. TTC will refer patients for dental health services, violence prevention, STI testing and treatment, child safety services,

homelessness, and obesity/weight management. TTC does not have sufficient financial and staffing resources to address all needs to meet patients' health priorities. TTC believes that collaboration is an effective way to pool and/or match existing health-related resources in meeting the health needs in SPA 2.

IX. Plan to Update the Assessment and Implementation Strategy

The inpatient facility staff in collaboration with TTC's in-house evaluation staff will develop a timeline and tracking log to monitor the implementation of the plan. The tracking log will serve as a tool to determine the progress of the implementation and to determine whether the goals and objectives are being met as indicated by the indicators and outcomes. The tool will alert the facility staff to define and implement corrective actions if outcome measures are not being met.

X. lan to Document Implementation Strategy

The inpatient facility staff in collaboration with TTC's evaluation staff will document and prepare quarterly report to be presented to TTC management and TTC Board. The evaluation staff will keep and maintain all documents and reports related to CHNA and the Implementation Plan.

XI. Approval of the Implementation Strategy by TTC Board

The CHNA for TTC's Acute Psychiatric Hospital and the implementation strategy was presented and approved by TTC's on 3/27/13 and is documented in the meeting minutes.

XII. Adoption of the Implementation Strategy

TTC management met with Inpatient Facility staff to present and discuss the adoption of the Implementation Strategy. TTC management will also discuss the timeline of the Implementation Strategy. In addition, TTC's in-house evaluation staff will present to the facility staff the tracking and monitoring tool to assess the progress of the Implementation Strategy.

XIII. Posting the CHNA on TTC's Website

As a requirement of the Bureau of Treasury and IRS, the CHNA report and Implementation Strategy will be posted on TTC's website in the beginning of April, 2013. And both documents will be widely available for viewing by the public. TTC will provide clear instructions on how to download the documents with no special hardware or software required for downloads and TTC does not charge any fees for viewing the documents.

Literature Citations

Bennett, M.E., Bellack, A.S. & Gearon, J.S. (2001). Treating substance abuse in

schizophrenia: An initial report. *Journal of substance abuse treatment, 20,* 163-175.

Regier, D.A., Farmer, M.E., Rae, D.S., Locke, B.Z., Keith, S.J., Judd, L,L,, Goodwin, F.K. (1990). Comorbidity of mental disorders with alcohol and other drug abuse Results from the Epidemiologic Catchment Area (ECA) Study. *Journal of the American Medical Association, 264,* 2511-2518.

Dixon, L. (1999). Dual diagnosis of substance abuse in schizophrenia: prevalence and impact on outcomes. *Schizophrenia Research, 35,* S93-100.

Valley Care Community Consortium 2010 Triennial Needs Assessment for SPA 2

Healthy People 2020