



Casa Colina Hospital for Rehabilitative Medicine

**Community Benefit
Report for FYE 2014**

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Casa Colina Hospital Community Benefit Report for Fiscal Year Ending 2014

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Casa Colina Hospital Community Benefit Report for Fiscal Year Ending 2014

1. INTRODUCTION AND OVERVIEW

Casa Colina Hospital for Rehabilitative Medicine (CCH) is the core of a network of closely integrated services that have historically functioned as a continuum of care to provide for the needs of persons with or at risk of disabling conditions. The Hospital provides services to patients through its acute inpatient hospital, outpatient therapy services, physician-directed specialty clinics, satellite outpatient clinic in Azusa, and the pediatric outpatient unit. The Hospital operates under the corporate umbrella of Casa Colina, Inc. (CCI). Other parts of Casa Colina, also sub-entities of CCI, extend the continuum of care further: the Transitional Living Center, Adult Day Health Care, residential services, imaging services, the Outdoor Adventures program, and joint ventures/cooperative projects with local governments and other community agencies.

In FYE 2015 this continuum of care will be extended further with the opening of a medical/surgical unit of 31 beds, three operating rooms and one procedure room. This will initiate a major change in Casa Colina's scope of activities and ability to serve the community. The next report, in FYE 2015, will reflect preparations for this change that are occurring as this report is being prepared. This FYE 2014 report is written pertaining to Casa Colina as it has historically existed; for this reason the following paragraph is included.

Casa Colina's mission and culture as a medical rehabilitation provider has led it to define the community it serves as "persons who have disability or are at risk of disability." In the broadest sense, this includes a very large part of the total population because almost everyone is at risk of an event or medical condition that could lead to an episodic (time-limited) or chronic disabling condition.

Consistent with the California legislation of 1994 (SB 697) and more recent Federal requirements, the benefit planning process includes the following elements:

- A Community Health Care Needs Assessment (CHNA) for the population served by CCH that includes input from persons with a background in public health as well as patients, former patients, community members and other health care professionals. The most recent needs assessment was completed in March 2012. A new CHNA is being done now (2014) that is scheduled for completion in March 2015.
- Regular meetings of the Community Benefits Committee, a committee of CCH whose members include representatives from Casa Colina's Board of Directors, corporate leadership, community members, health professionals and dedicated staff.
- A history of cooperation in understanding needs and planning with other community agencies.
- A tracking system to verify community benefits implementation throughout Casa Colina's system of care.

Mission Statement and Goals of Casa Colina

The **Mission Statement** addresses the approach of Casa Colina to services for this community as follows:

Casa Colina will provide individuals the opportunity to maximize their medical recovery and rehabilitation potential efficiently in an environment that recognizes their uniqueness, dignity and self-esteem.

The goal of rehabilitation medicine and the multi-disciplinary array of therapy services is to address disabling conditions by preventing or remediating the impact of disability on a person's productive, independent pursuit of life. This is labeled "Tertiary Prevention" by the World Health Organization (see below).

The range of the more than 10,700 people admitted as patients in Casa Colina programs in FY 2014 (April 1, 2013 to March 31, 2014) continues to include persons of all ages and with many diagnoses. These range from episodic injuries such as a torn rotator cuff that can be managed as a part of everyday activities, to events that produce chronic disabilities that are truly life changing, such as severe traumatic brain injuries.

Founded in 1936, Casa Colina's first focus was on children recovering from polio and other crippling diseases. The goal was to help these children find a way to build productive, satisfying lives. This goal always looked beyond the medical control of a disease process to reintegrating the patient into community and family life. Casa Colina Hospital, as the core of the rehabilitation effort, continues to look beyond medical recovery to use the other services in the Casa Colina network – the Transitional Living Center, the Adult Day Health Care Center (now called Community Based Adult Services), Outdoor Adventures, and residential services – to work toward the best outcomes for patients.

Types of Prevention Related to Persons with Disabilities

In general, Casa Colina's service to the community approaches remediating disability in three ways:

Preventing disability is part of rehabilitation's interaction with the community at large through education and advocacy for safety, from use of seat belts to concussion management programs in sports. Activities related to this **Primary Prevention** are part of Casa Colina's on-going Community Benefit program.

Managing the risk of disability, for those for whom the disability (or, for those disabled but stabilized, adding disability burden) has not yet occurred. This risk is addressed through specialized medical diagnosis, risk assessment, and pro-active intervention, which may be at the personal, family, or community and environmental level. In Public Health these types of early detection and prospectively-applied interventions are called **Secondary Prevention**. Their purpose is to prevent the occurrence or exacerbation of disability or further medical complication, where risk has been identified. Outreach programs, screenings, education, and

creating a good environment to retain specialist physicians in the community are part of Casa Colina's Community Benefit effort in this dimension.

Intervening to counteract disability. Casa Colina's response is its continuum of rehabilitation care: effectively pursuing medical recovery, rehabilitation therapies, and education/training in adaptation, life-adjustment, and adaptive strategies that may be, as with Secondary Prevention, at the personal, family, or community and environmental level. In Public Health this application of rehabilitation is spoken of as **Tertiary Prevention**. Its aim is to prevent the disabling condition from interfering with individual's pursuit of living, in whole or in part. The main components of Community Benefit in this regard are the provision of rehabilitation care to individuals (and support services/training to families members and care-givers); the training and development of staff to provide this care; subsidizing particular programs that provide important functions but cannot achieve positive financial nets such as Children's Services or, at times, the Hospital itself; and the provision of care on a charity, subsidized or unreimbursed basis when needed.

2. DEFINITION OF COMMUNITY

Casa Colina has defined the community it has historically served as persons with or at risk of disability. More precisely these are persons who can benefit from medical and rehabilitation interventions to prevent, remediate, or delay progression of disabling conditions and the impact on function, independence, and quality of life. Population statistics (Census Bureau 2004) show that about 12.3% of all people in the United States will have a disabling condition at any given time, indicating that there are about 166,331 persons with disability¹ in Casa Colina's immediate 10- to 15-mile radius, from which more than 75% of its patients originate. For specific specialty programs, Casa Colina also draws patients from Southern California, the western states and the Pacific Rim.

The demographics of this population vary greatly by city in terms of age, ethnicity, and socio-economic status, but overall it is highly diverse. As an example, among the 17 cities closest to Casa Colina, one has a White population of 74.7% and another has 9.1%, while the Hispanic/Latino population is at 83.1% in one city and 16.7% in another. Casa Colina's staff and community of persons with disabilities reflect that diversity. A more detailed review of these demographics based on data from FYE 2011 is presented in the Health Care Needs Assessment of 2012 and its Supplement that is an Attachment to this report. The following tables show two basic elements of those demographics with the most recent data for FYE 2014.

¹ For 2014 there was a total estimated population of 1,352,300 persons in Casa Colina's primary catchment area, from which 75% of patients originate (extrapolated from 2010 Census data). This area of 17 cities is described by 26 zip codes: 91786, 91784 – Upland; 91730, 91701, 91737, 91739 – Rancho Cucamonga; 91750 – La Verne; 91711 – Claremont; 91762, 91764, 91761 – Ontario; 91710 – Chino; 91767, 91766, 91768 – Pomona; 91709 – Chino Hills; 91763 – Montclair; 91773 – San Dimas; 91702 – Azusa; 92336 – Fontana; 91740, 91741 – Glendora; 91724 -- Covina; 91765 – Diamond Bar; 91789 – Walnut; and 91791 – West Covina.

Gender Distribution, Casa Colina Hospital and All Entities, FYE 2014

	CCH Number of Admissions	CCH Percent	All Entities Number of Admissions	All Entities Percent
Total number ²	10,528	100.00%	10,761	100.00%
Other	0		1	0.01%
Female	5,642	53.59%	5,696	52.93%
Male	4,886	46.41%	5,064	47.06%

Ethnicity/Race of Casa Colina Hospital and All Entities Patients, FYE 2014

Ethnicity	CCH Number of Persons	CCH Percent	All Entities Number of Persons	All Entities Percent
Reporting number	4,695		4,761	
Asian & Pacific Islander	215	4.58%	219	4.60%
Black / African- American	250	5.32%	255	5.36%
Filipino	2	0.04%	2	0.04%
Native American / Eskimo /Aleutian	109	2.32%	109	2.29%
Hispanic	2,199	46.84%	2,232	46.88%
White/Caucasian	1,920	40.89%	1,944	40.83%
<i>Totals</i>	<i>4,695</i>	<i>100.00%</i>	<i>4,761</i>	<i>100.00%</i>

Patients at Casa Colina voluntarily self-identify in terms of ethnicity/race. In FYE 2014, 4,761 patients of all Casa Colina entities chose to self-identify, 55.72% of the total (8,544 individuals) compared to 35.44% in FYE 2013. The data analysis reflects the responses of the 4,695 Casa Colina Hospital patients who chose to self-identify, 55.46% of the total (8,465 individuals), compared to 25.9% in FY2013.

3. COMMUNITY BENEFITS PLANNING COMMITTEE

The Committee is currently composed of seven (7) people whose diversity may be characterized in the following ways (some individuals fall into more than one diversity category):

- Community member
- Individuals with disabilities
- Ethnic/socio-economic diversity
- Member of Casa Colina Board of Directors
- Member of Hospital and Casa Colina corporate leadership

² This number represents admissions of individual persons to distinct programs. For example, if an individual is admitted to Casa Colina Hospital as an inpatient (Team 101) two times in the year, he/she is counted as one person. If that same person is admitted as an inpatient (Team 101) then later admitted as an outpatient (Team 106) that counts as two admissions, as a different type of service is being provided. For comparison, there were 2,410 additional admissions if all admissions to all entities were counted, irrespective of person.

- Community Benefits dedicated staff

The Committee functions as a Committee of the Hospital and documentation for its activities is kept as part of the Hospital's committee records. Community benefits programming discussed by the committee is brought forward to the Board of Directors through the inclusion of the memos detailing activities of the Committee in board informational materials and the discussion at board meetings is informed by the presence of those board members who are also Committee members. The most recent Community Benefits Committee meetings, January 6, 2014 and July 21, 2014, focused on the implementation of the next Community Healthcare Needs Assessment, the effectiveness of the Community Benefits Department, the preparation of this present document, and the Plan for FYE 2015.

In addition, in identifying goals, objectives and use of resources, the Casa Colina Board of Directors and management has taken the following issues into consideration during its deliberations at board meetings throughout the year, and specifically at the Annual Board Retreat, last held November 14 to 16, 2013. The discussion at this meeting, with the whole board participating, precedes the work of the smaller Community Benefits Committee. The 21 members of the board reflect the wide diversity of the community served by Casa Colina, in terms of gender, profession, ethnicity, racial heritage, disability status and age. The decisions of the board and management to commit budget funding to projects addressing these issues and advancing these objectives are their implementation of the Community Benefit Plan.

4. ASSESSING NEED

Casa Colina Hospital performed a **Community Health Needs Assessment (CHNA)** in FYE 2012 which is one basis of this Community Benefit Plan and its implementation. It was performed by James Griffith (ABD) at Claremont Graduate University, Institute for Organizational and Program Evaluation Research, under the direction of Tarek Azzam, Ph.D. The **Report** and its **Supplement** are included as an **Attachment**. There was a discussion of the Assessment in this narrative in the FYE 2012 report which is not repeated here. The results of the Assessment are included in the Logic Model below as part of this Community Benefit Plan.

The 2012 Needs Assessment replicates in many ways the findings of previous tri-annual assessments. It included the telephone and web-based survey as previously done and added a new element, which was a focus group composed of health care and public health professionals.

A new CHNA is in process of preparation with a public release date scheduled for March 2015. It is being done through a consultancy arrangement with the Center for Non-profit Management in Los Angeles, under the direction of Maura Harrington, PhD.

5. COMMUNITY BENEFIT PLAN FOR FYE 2014, SETTING PRIORITIES

The FYE 2012 Needs Assessment revealed trends from the patients'/consumers' point of view that are consistent with previous needs assessments although there is some variability when age

of the person is considered. There are a few new specific recommendations that will be discussed during the year and addressed in the Plan for FYE 2014 (Results) and 2015 (Expectations). There are two global areas of concern based on the needs of the population that Casa Colina has historically served:

- **Access to health services.** People have concerns about having adequate health insurance and access to basic medical services and specialized medical/rehabilitation services. This “access” can be financial, geographic and whether the providers will be sustained over time, particularly when funding is challenged. Additionally there is the question of whether health care providers are experienced and welcoming in working with individuals with disabilities.
- **Access to quality of life.** People have concerns about preventive services, health support services, accessible recreation, transportation, employment, social integration and educational services.

Although some of these needs go beyond Casa Colina’s role as a service provider, these needs all fall under the purview of the goals of comprehensive rehabilitation for individuals as described in Casa Colina’s mission. These needs are reflected in Casa Colina’s strategic plan and its program of services, which speak about the following objectives, among others:

- Ensure Casa Colina’s continued capability to perform charitable and community benefit functions by management of resources, exceptional business management, and development of fund raising with Board and community engagement.
- Provide strong economic stability by development of additional sources of operational revenue consistent with the core mission, to ensure sustainability of the institution itself. A major landmark in the implementation of this goal will be the opening of a 31-bed addition to Casa Colina Hospital that is scheduled to occur in April 2015. This will be a medical-surgical facility and will be a significant change in the capacities and responsibilities of Casa Colina in the community’s health care fabric.
- Participate in building a vibrant community that recognizes the value of rehabilitation and specialized medicine as part of the community’s network of health services, and the intrinsic value of individuals of all abilities in that community.
- Create an environment for physician specialists and other rehabilitation professionals that attracts and retains them in the community. Offer support to advance the state-of-the-art in the health professions, including working with students to prepare the next generation of health care professionals.

Community Benefits Priorities

The priorities for Community Benefits are derived from the community Needs Assessment, the experience and needs of staff and professionals in the community, and the priorities for the sustainability of Casa Colina as defined by the Board who are themselves community members.

Benefits for uninsured, underinsured and low income persons

Priority 1. Provide free care to patients at Casa Colina Hospital who are low/moderate income and uninsured or not adequately insured.

Priority 2. Subsidize care at Casa Colina Hospital that is provided at a discount through government programs for patients who are low/moderate income and uninsured or not adequately insured.

Benefits for patient and community health

Priority 3. Subsidize specialized Hospital and other programs that are of recognized community benefit but are not self-supporting financially

Priority 4. Improve the health of the community in general through prevention, health screenings, education, support groups and assistance to individuals and persons designated by groupings of diagnoses or functional status

Community Benefits operations

Priority 5. Organize and operate the Community Benefits program.

Benefits for health professions education

Priority 6. Education of health professionals in general and those focused on rehabilitation in particular and the needs of persons with or at risk of disabilities

Research

Priority 7. Conduct research to and improve clinical practice and the organization of delivery of health care to the community, particularly with respect to rehabilitation and the issues of individuals with disabilities

Benefits for community building and support of other community groups

Priority 8. Support other community organizations, particularly those that are focused on Casa Colina's population of interest and on general health care concerns, both financially and through collaboration and assistance

Priority 9. Support improvement of the community in general by working in collaboration with other organizations and supporting capacity building including concerns such as housing, safety, economic development, disaster preparedness, environment, leadership, coalition building, and advocacy for persons with disabilities, all of which affect health and well-being in general

Priority 10. Support and participate in regional and national organizations that develop policy recommendations and are advocates for the health care interests of individuals with disabilities. (This category applies as a recognized community benefit for the State of California but is not recognized in the same way in the federal definitions as currently stated in the IRS Form 990 Instructions.)

Recognizing that non-profit hospitals in California are mandated to report their community benefits activities to both the State of California Office of Statewide Healthcare Planning and Development and the federal government through the IRS Form 990 Schedule H filing, it is useful and efficient for Casa Colina Hospital to set up the organization of these priorities and the subsequent Plan and the Report of Community Benefits that will be made according to certain Community Benefit line items that appear in IRS Form 990 Schedule H (2010). These Community Benefits are further interpreted to reflect the specific concerns of the state of California's Community Benefit Program and Casa Colina's unique mission and community in cases where the definitions of the mandates vary.

(See Planning Logic Model on next page)

Planning for Community Benefits Based on Community Health Care Needs and their Importance

Needs as prioritized by the tri-annual Community Healthcare Needs Assessment of 2012. Section numbers (§x.xx) refer to the numbering system in the tally "Summary Casa Colina Hospital Community Benefit Report, FYE 2014" and the following narrative, all of which begin on page 19.

<i>Needs/Goals</i>	<i>Actions taken/proposed</i>	<i>Results FYE 2014</i>	<i>Expectation FYE 2015</i>
1 Adequate health insurance	1a. Education about coverage for individuals (pro-bono consultation and information one-on-one) and group audiences (public seminars)	1a. Continue public education programs (part of overall education plan, §2.09) and pro-bono individual consultation that come from phone, email and direct requests §2.12 (\$7,808 in FYE 2014).	1a. Continue public education programs (part of overall education plan, §2.09) and pro-bono individual consultation that come from phone, email and direct requests §2.12 (expect \$8,000 in FYE 2015). Note that that nature of the education and consultation will change subsequent to the opening of the new hospital services in ~April 2015.
	1b. Support and collaboration of advocacy through state and national organizations to maintain coverage by MediCare, Medi-Cal, HMOs, PPOs, VA, DoD, etc.	1b. Work with and support state and national organizations, §8.01; expense of \$13,000 in FYE 2014.	1b. Continue work with state and national organizations with about same expense, §8.01.
2. Access to healthcare services / services accommodate persons with disabilities	2a. Case management advocacy to third party payers to ensure appropriate authorization for the best patient care possible	2a. Continue strong case management advocacy; part of hospital regular operations.	2a. Continue strong case management advocacy; part of hospital regular operations.
	2b. Means-tested Free Care Fund	2b. Increase Free Care to meet need, §1.01 (increased 34% from FYE 2012 to FYE 2014; \$145,000 to \$201,085 in the Hospital and \$64,700 to \$79,969 in other parts of Casa Colina).	2b. Increase Free Care to meet need, §1.01 (expect increase from FYE 2014 to meet the growing need)
	2c. Operational subsidy of Medi-	2c. Continue to provide subsidy for	2c. Continue to provide subsidy for

<i>Needs/Goals</i>	<i>Actions taken/proposed</i>	<i>Results FYE 2014</i>	<i>Expectation FYE 2015</i>
	Cal shortfall.	Medi-Cal shortfall from operational funds, §1.02 (\$235,210 in FYE 2012 increased to \$689,156 in FYE 2014).	Medi-Cal shortfall from operational funds, §1.02 (expect substantial increase for FYE 2015).
	2d. Operational and donation-based subsidy of Signature programs.	2d. Continued operational and donation-based subsidy of Signature programs but continued to work on reducing this need, §5.03 to §5.14. Hospital programs subsidy was \$836,397 and non-Hospital programs were \$654,325.	2d. Will continue to provide this subsidy but will also continue to work on ways to decrease it, §5.03 to 5.14.
	2e. Support of Physician Clinics and Medical Office Building to increase availability of physicians with understanding and expertise in working with individuals with disabilities who will also take care of regular medical needs.	2e. Medical Office Building is open and fully tenanted. Physician engagement is an on-going priority. These were not quantified in terms of Community Benefit.	2e. With the opening of the new medical/surgical unit in spring 2015, physician engagement will continue to be an on-going top priority. The scope of this section will expand to include persons with all medical needs that can be addressed on an elective basis.
	2f. Education program for shadowing, internships, residencies, fellowships and mentoring to ensure that medical and rehabilitation professionals will be available and experienced in the future.	2f. These educational programs to prepare the next generation of professionals and continue the education of current professionals, §4.01 to 4.08, were provided at an unreimbursed cost of \$386,777 in FYE 2012 and \$501,436 in FYE 2014.	2f. It is expected that these programs will continue to be provided and will grow with the expansion of the scope of service generally at Casa Colina and additional individuals served, §4.01 to 4.08. The community investment is expected to increase to about \$550,000.
3. Living independently / as independently as possible	3a. Continuum of care designed to bring patients the ability to succeed in community re-entry at specified level	3a. The continuum of care, part of Casa Colina's basic organizational structure, continues to be developed and refined. This is not quantified in	3a. This effort will continue. In FYE 2015, looking forward to FYE 2016 with medical/surgical patients, the issues addressed by this initiative

<i>Needs/Goals</i>	<i>Actions taken/proposed</i>	<i>Results FYE 2014</i>	<i>Expectation FYE 2015</i>
		terms of community benefit. Casa Colina's unique Navigator program for discharged patients with traumatic brain injury has completed its pilot phase with positive results leading to a new, expanded program to provide similar services to all patients designated as High Risk Discharge.	become even more important.
	3b. Support groups to give on-going assistance to living independently	3b. Casa Colina continues to provide support groups itself, or assist outside-facilitated support groups by providing meeting space and other accommodations, §2.08. This was provided at a cost of \$10,680 in FYE 2014.	3b. The expectation is that the range of support groups will continue, with the normal variations year to year based on needs of specific groups of patients and community members, §2.08.
4. Adequate transportation to medical and other appointments	4a. Historical support of Senior Services Center's Get-About bus program with consortium; continued annual support.	4a. The annual support of the Senior Services Center continues with their convening a consortium of social workers in our mutual service area. The Get-About bus service has become self-sustaining. On another issue, because of the increasing size of Casa Colina's parking lot and distance some patients need to walk from parking to the services they need, Casa Colina has established a free tram system that operates 7 am to 7 pm. As this is an internal operation of Casa Colina it is not categorized as a community benefit,	4a. Continuation of support of Senior Services Center initiatives, whether or not directed at transportation, and the parking lot tram service will continue.

<i>Needs/Goals</i>	<i>Actions taken/proposed</i>	<i>Results FYE 2014</i>	<i>Expectation FYE 2015</i>
		but particularly for persons with disabilities it has become an important part of making campus services accessible.	
5. Access to physical fitness activities	5a. Daily community aquatic exercise program.	5a. This program provides aquatic exercise for community members with weight-bearing and/or joint issues, at a nominal cost (\$40 per month) under the direction of Certified Athletic Trainers. It occurs three times a day on a daily basis. There were a total of 750 sessions a year with about 10,200 participant visits, part of §2.14. There was a total unreimbursed cost of \$30,513 in FYE 2014.	5a. The program will continue on the same basis with approximately the same cost, part of §2.14.
	5b. Daily community access to specialized gym through Community Fitness Program	5b. Casa Colina Hospital's two exercise gyms, one in the inpatient facility and one in the outpatient, are available for use by community members with limited oversight by staff, part of §2.14. In addition to providing gym space for clinical patients, these gyms provided 582 sessions for 5,088 participant visits of 110 individuals in three programs: Assisted Fitness Program, Community Land Fitness Program; No Boundaries SCI Fitness Program. Participants paid a monthly fee of \$40 except in cases	5b. This program will continue on the same basis in FYE 2015. Additionally, the therapy staff has constructed an integrated program to improve the continuity of exercise behaviors from a person's patient status to community living status that uses Casa Colina's gyms initially. This pilot project, "No Boundaries," started in FYE 2014 with five participants and currently seeking grant funding to expand the number of people it can accept.

<i>Needs/Goals</i>	<i>Actions taken/proposed</i>	<i>Results FYE 2014</i>	<i>Expectation FYE 2015</i>
		where it was waived. There was a total unreimbursed cost of \$29,739.	
	5c. Outdoor Adventures	5c. Casa Colina Outdoor Adventures (ODA) provides a means for patients, people newly discharged, and persons with disabilities living in the community to have access to challenging experiences in the outdoors such as sailing, skiing, waterskiing, fishing, camping, and the like. The supportive environment is geared to offer only as much assistance as necessary and encourage problem solving a goal achievement. It is supported by modest participation fees and very significant subsidies acquired through fundraising. In FYE 2014, there were 320 participant visits in 16 excursions, §5.05. The subsidy to provide these trips represents \$168,530 in community benefit, however this is not listed as a Hospital community benefit because ODA operates under another Casa Colina corporation.	5c. Outdoor Adventures expanded slightly in FYE 2014, and is planned to expand slightly again in FYE 2015, with a larger roster of trips and continued focus on serving patients, discharged patients, and community members, §5.05.
	5d. Wellness and Prevention: Specialized community programs for people with Parkinson's, MS, Fibromyalgia, stroke, autism, and others.	5d. These diagnostic-specific targeted groups, part of §2.14, provided education and exercise that is a model for what can be done at home. In FYE 2014 these programs	5d. It is expected that these programs will maintain operations at about the same level in FYE 2015.

<i>Needs/Goals</i>	<i>Actions taken/proposed</i>	<i>Results FYE 2014</i>	<i>Expectation FYE 2015</i>
		(apart from Aquatic Fitness at 5a above and the land-based exercise program at 5b) provided 228 people with 914 participant visits at 128 separate events, at an unreimbursed cost of \$11,239.	
6. Socializing with others	6a. Support groups, such as the Post-Polio Syndrome Group and the other diagnosis-related community and exercise programs.	6a. Support groups offer opportunities to socialize with similar-diagnosis peers in formal and informal settings, §2.08. Casa Colina provided funds of \$10,680 to facilitate these activities in FYE 2014, a total of 8 support groups that had cumulative total of 92 meetings and 1,245 support group visits, an average of 13.5 people per group.	6a. It is expected that support group activity will continue at about the same level or increase slightly with the opening of new physician offices on the Pomona campus.
	6b. Outdoor Adventures.	6b. As well as providing an accessible venue for physical activity (5c. above) Outdoor Adventures' other main purpose is to provide a venue for social interaction that is not clinically based, but based on challenging activities the participant chooses. In FYE 2014, there were 320 participant visits in 16 excursions, §5.05. The subsidy to provide these trips represents \$168,530 in community benefit, however this is not listed as a Hospital community benefit because ODA operates under	6b. Outdoor Adventures expanded slightly in FYE 2014, and is planned to expand slightly again in FYE 2015, with a larger roster of trips and continued focus on serving patients, discharged patients, and community members, §5.05.

<i>Needs/Goals</i>	<i>Actions taken/proposed</i>	<i>Results FYE 2014</i>	<i>Expectation FYE 2015</i>
		another Casa Colina corporation.	
	6c. Children's group programs, particularly Kids' Crew, Teen Scene, Early Intervention, and the pediatric aquatics program.	6c. Socialization and social skills are prime foci of many children's programs because of the importance of this learning to the developmental process in general. Children with autism spectrum disorders have this as a special focus as deficits in this area are characteristic of the disorder. Therefore there are many programs aimed at different ages and aspects, many of which need subsidy to continue and provide treatment at an effective standard. Children's Services was the recipient of operating subsidies in the amount of \$769,315 in FYE 2014, \$5.03. In terms of services, 1,147 pediatric patients were seen at Casa Colina as a whole in FY 2014, and 10,499 treatment visits were provided at Children's Services. (Services to children were provided through other venues as well such as audiology, the regular outpatient program, and physician services. Contract services to collaborating organizations are not included here.)	6c. It is expected that the subsidy necessary for these programs will diminish in the next year because of easing of the state's budget crisis. However, the number of patients continues to increase and the locations of treatment continue to be more diverse (home, school and community sites in addition to clinic-based services), which could impact the subsidy need as well.
7. Being physically able to get around in the	7a. For patients these issues are addressed as part of discharge training for patient and family.	7a. As part of each patient's discharge plan, consideration is given to mobility and transportation	7a. This individualized process will continue for patients.

<i>Needs/Goals</i>	<i>Actions taken/proposed</i>	<i>Results FYE 2014</i>	<i>Expectation FYE 2015</i>
neighborhood and outside the neighborhood		needs for home and community re-entry. Planning and training is included in the treatment program before discharge, and carried over through support groups and connections to community agencies.	
	7b. For community members, these issues are addressed in support groups and diagnosis-related groups.	7b. This on-going support continues, see Support Groups, §2.08	7b. This on-going support will continue, see Support Groups, §2.08

6. MEASURING COMMUNITY BENEFITS EFFORTS AGAINST ALIGNMENT WITH GOALS FOR COMMUNITY HEALTHCARE

In the following tables we present another way of looking at how much Casa Colina is achieving its stated goals. Specifically, this year a select list of goals was chosen and each event or activity related to community benefits was retroactively associated with one or two of the goals, if the activity's purpose applied to exploring, resolving, promoting or managing that goal. One set of five goals was chosen based on the most important findings of our 2012 Community Health Care Needs Assessment. A second set of four goals was chosen from the Federal Government's Healthy People 2020 list.

There are many more goals that could have been chosen, but as a first attempt at making this type of correlation, we have gained a good deal of information. In the next year, this goal setting priority will be guided by findings of the new Community Health Care Needs Assessment, which is in preparation now and will be published in early 2015.

(Note that the opportunity was made to assign two goals to each event, so the total sum of percentages is 200% in each case, with +/- for rounding errors.)

Goals for Casa Colina Community's Healthcare as Expressed in Community Health Care Needs Assessment (2012)

<i>Goal</i>	<i>Events promoting this goal</i>	<i>Percentage of all events</i>
1. Increase number of persons with disabilities who are living as independently as possible	104	76%
2. Increase access to healthcare providers who accommodate and are knowledgeable about persons with disabilities	64	47%
3. Increase opportunities for persons with disabilities to socialize with others	27	20%
4. Increase access to physical fitness activities for persons with disabilities	26	19%
5. Increase satisfaction of persons with disabilities to be able to get around the neighborhood	19	14%
Blank / Other	34	25%
Total	274	201%

Goals for Healthcare as Expressed in Selected “Healthy People 2020” Priorities

<i>Goal</i>	<i>Events promoting this goal</i>	<i>Percentage of all events</i>
1. Increase percentage of persons with disabilities who have good community integration	95	69%
2. Decrease percentage of older adults with functional limitations	95	69%
3. Increase percentage of 3-year-olds who have been screened and, if indicated, evaluated and treated for developmental disabilities and autism spectrum disorders	18	13%
4. Increase the percentage of newborns who are screened for hearing loss	14	10%
5. Blank / Other	52	38%
Total	274	199%

6. SUMMARY OF CASA COLINA HOSPITAL COMMUNITY BENEFIT RESULTS FOR FYE 2014

Using the categories in §5 as a guide, the summary results for FYE 2014 are shown below with a column that indicates separately community benefits that are delivered by operational units of Casa Colina that are not within the Hospital. At the bottom of the table, the two categories are summed to give a total for the community benefit efforts for the year. Following the table is a Narrative discussing the community benefits delivered during the year in detail. A separate section following the Narrative describes “Public Interest Initiatives” that are items of value to the community but are not designated as community benefits³.

Summary Casa Colina Hospital Community Benefit Report, FYE 2014

		FYE 2014 Hospital	FYE 2014 Other Casa Colina Entities	FYE 2014 Total, All Casa Colina Entities
1.00	Benefits for persons who are uninsured, underinsured, and low income			
1.01	Free Care Program	\$201,084	\$71,969	\$273,053
1.02	Unreimbursed Medicaid / Medicare	\$689,156		\$689,156
2.00	Community Health Improvement: Provide free/low-cost screenings, preventive care, and support services			
2.01	Free Sports Medicine Screenings - Pomona	\$50,710		\$50,710

³ As described in: *Advancing the State of the Art in Community Benefit: A User’s Guide to Excellence and Accountability* (ASACB), Public Health Institute, November 2004; see Narrative section for discussion.

		FYE 2014 Hospital	FYE 2014 Other Casa Colina Entities	FYE 2014 Total, All Casa Colina Entities
2.02	Free Sports Medicine Screenings - Azusa	\$40,811		\$40,811
2.03	Free Audiology Screenings	\$27,691		\$27,691
2.06	Free Varicose Vein Screenings	\$1,477		\$1,477
2.05	Vaccinations	\$0		\$0
2.08	Support Groups	\$10,680		\$10,680
2.09	Community Health Education	\$103,635		\$103,635
2.10	Other direct aid to patients and families	\$30,250		\$30,250
2.11	Cultural/linguistic competency	\$9,078		\$9,078
2.12	Information and referral services	\$7,808		\$7,808
2.14	Community preventive health and wellness programs	\$71,853		\$71,853
3.00	Community Benefit Operations			
3.01	Community Benefits dedicated staff	\$127,491		\$127,491
3.02	Community benefits expenses, contracts and consults	\$112,527		\$112,527
3.03	Fund raising expenses to support community benefits programs		\$181,660	\$181,660
4.00	Health Professions Education			
4.01	Physician education, fellowships, shadowing, mentoring, rotations, etc. expenses	\$105,000		\$105,000
4.02	Nursing education and training, rotations	\$173,262		\$173,262
4.03	Physical Therapy mentoring, internships, externships	\$105,374		\$105,374
4.04	Occupational Therapy mentoring, internships, externships	\$19,737		\$19,737
4.05	Speech mentoring, internships, externships	\$3,489		\$3,489
4.06	Neuropsychology mentoring, internships, training	\$74,253		\$74,253
4.07	Therapeutic Recreation internships, training, mentoring	\$51		\$51
4.08	Community Professionals Health Education	\$20,270		\$20,270
4.09	Human Resources Residencies/Internships		\$513	\$513
5.00	Subsidized Health Services: Support treatment programs with recognized value to the community that require subsidy to continue			
5.01	SEP Team 105	\$59,271		\$59,271
5.03	Children's Services Teams 118-126	\$769,315		\$769,315
5.04	Sports Medicine Team 173	\$7,443		\$7,443
5.05	Outdoor Adventures Team 694 (+Land Meets Sea)		\$168,530	\$168,530
5.06	Padua Homes Teams 410-413		\$485,795	\$485,795
5.12	Wounded Warrior program: Use of donor designated funds	\$368		\$368
6.00	Research: Provide an evidence base for effective treatment and organization of health services			
6.01	Dedicated research department budget	\$148,558		\$148,558
6.02	Research programs expense, for CCH	\$14,471		\$14,471
6.03	IRB expenses	\$6,144		\$6,144

		FYE 2014 Hospital	FYE 2014 Other Casa Colina Entities	FYE 2014 Total, All Casa Colina Entities
7.00	Support of Community Groups			
7.01	Support of community individuals and groups	\$56,000		\$56,000
7.02	Cost of fund raising for community benefit efforts		\$181,660	\$181,660
7.03	Community building through outreach to and collaboration with community organizations	\$14,072		\$14,072
8.00	Support of regional, state and national groups			
8.01	Support of regional, state and national advocacy organizations	\$13,000		\$13,000
	Total Community Benefit effort	\$3,074,330	\$908,467	\$3,982,796
		Hospital Only	Other Entities	All Entities

Tally verified against Excel sheets 7/22/14

8. NARRATIVE OF COMMUNITY BENEFIT ACTIVITIES AND RESULTS FOR FYE 2014

1.00 Charity and subsidized care for persons in need

1.01 Charity care

Direct Charity Care for low income, uninsured and underinsured persons is provided at Casa Colina through an application and means-tested determination process. There are signs posted throughout the facility in English and Spanish alerting patients about the availability of free care. Announcements also appear on Casa Colina's web site and in video materials for patients.

In FYE 2014 \$201,084 in charges net of discounts were provided to patients in charity care at Casa Colina Hospital, an increase of almost \$30,000 from FY2013. In addition, direct charity care for other parts of Casa Colina's continuum of care, principally the Transitional Living Center, was \$71,969, for a combined total of \$273,053 in direct charity care. This uncompensated care funding provided services to 97 patients in Casa Colina Hospital (inpatient and outpatient) and 11 patients in other Casa Colina facilities.

1.02 Government-Sponsored Health Care

Casa Colina Hospital experienced losses of \$689,156 on services provided to Medi-Cal patients on a fully allocated cost basis in FYE 2014 compared to \$478,553 in FY2013. This year's subsidy represented services to approximately 3000 admissions.

2.00 Community Health Improvement

2.01; 2.02 Free Sports Injury Screenings / Primary Care

Casa Colina provides free community Sports Injury Screening Clinics. Every Sunday morning (except legal holidays) there is a clinic at the Pomona campus and each session is 3.25 hours. The Clinic at the Casa Colina Azusa outpatient clinic is on Monday evenings, where each session is 2 hours. An orthopedist or rehabilitation physician is available at no cost to members of the public. Additionally, a physical therapist or Athletic Trainer is available and there is basic radiology on the Pomona campus. In FYE 2014, 875 individuals were seen at Pomona and Azusa combined, compared with 634 in FYE 2013, with an average of 15 x-rays per session at Pomona. The expense of providing this service in FYE2014 was \$50,710 in Pomona and \$40,811 in Azusa. For the 875 individuals receiving services in FY 2014, the average cost approximately \$105 per person.

2.03 Free Audiology Screenings

The Hospital's Audiology service performs free hearing screenings, for all ages from infants to seniors. In FYE 2014 Audiology performed 401 free screenings. The cost of providing these services in was \$27,691, averaging \$69 per person.

2.04 Free Balance Screenings

Casa Colina staff provided screenings for balance, strength deficiency, and other physical therapy issues at Casa Colina and at community locations such as senior centers and health fairs in the community. These screening were accompanied by education and discussion about etiology and self-help practices and are represented in §2.14, Preventive Health and Wellness Programs.

2.05 Free Vaccinations

Casa Colina has an annual vaccination program for staff members and others that includes Flu vaccinations and TDaP. These services for staff are not identified as a community benefit.

2.06 Free Varicose Vein Screenings

Through its imaging center, Casa Colina has begun providing screening for issues with varicose veins. In FYE 2014 the number of patient screened was 37 at a cost of \$1,477, averaging \$40 per person.

2.08 Support Groups

In FYE 2014 Casa Colina hosted 8 support groups that had a cumulative total of 92 meetings, providing services to about 230 individuals over the course of 1245 encounters. Some of these groups are led or directed by Casa Colina staff, others are provided in cooperation with outside organizations that use Casa Colina facilities. Historically, for some activities a fee is charged and the Community Benefit valuation accounts for those revenues. In this reporting year there were no fees charged for these events. Overall these support groups were provided/accommodated at a total unreimbursed cost of \$10,680, averaging \$9 per encounter or \$46 per individual served. These support groups included:

- ALS Support Group
- Brain Injury Support Group

- Brain Injury Caregiver Support Group
- Fibromyalgia women's group
- Fibromyalgia community support group
- Fibromyalgia teen support group
- Parent Support Group (Children's)
- Post Polio support group
- SCI Support Group (facilitated by WYNGS)
- Up for Downs Parents Support Group

2.09 Community Health Education

Lectures, Workshops and Presentations

In FYE 2014 Casa Colina presented 30 Community Health Education lectures and workshops both on the Casa Colina campus and off. The total number of visits of people to these events was about 4,503, an increase of 282% from FY 2013, when visits were 1,180. The unreimbursed cost to Casa Colina of these activities was \$103,635. The bulk of this expense was local newspaper advertising, which continues to be the best way to reach a broad spectrum of people. Email, internet and social media are also used and are effective for selected issues and events, but newspaper advertising is still the most productive way to reach out to new audiences in the local community.

Following is a representative list of the events that occurred in FYE 2014 in which the speakers were physicians, therapists and other allied health professionals. Note that the Annual Trends in Autism Conference, which Casa Colina originated 13 years ago, and which in recent years has been done in collaboration with Western University of Medical Science, continued this year totally under the auspices of Western U, with a financial contribution from Casa Colina.

- 29th Annual IACC Spring Conference, Presentation
- Abilities Expo, Presentation
- APU Health and Lifestyle Expo - education about role of rehab continuum in prevention and recovery
- Arthritis and total joint replacement, an overview
- Arthritis, Osteoarthritis and Rehab / Kiwanis Club
- Claremont retiree seminar about rehabilitation
- Education about arthritis and total joint replacement
- Head Injuries: Understanding and Treating
- Hip Fractures: Education, Prevention, Rehabilitation
- La Verne Health Fair - education about role of rehab continuum in prevention and recovery
- Library training at Diamond Bar Library
- Library training at The Library, Victoria Station
- Living with Arthritis
- Living with Fibromyalgia
- Low Vision Rehab - Low Vision Life Enrichment Series (1)
- Low Vision Rehab - Low Vision Life Enrichment Series (2)
- MS Forum and Expo
- Oh, My Aching Back! - Community Seminar
- Overview of the role of rehabilitation in recovery from illness and injury
- Parents Place Annual Information Fair
- Parkinson's: Community Lecture
- Power over Parkinson's
- Round table discussion with former patient, education about rehabilitation, Q and A
- Spring Senior Health Fair at Pomona Fairplex, Presentation

- Stroke Awareness - Discussion with Stroke Experts
- Transition (to Adulthood) Laws and Regulations, Workshop
- Up for Downs Walk-a-thon, presentation
- Village Venture/Claremont - education about role of rehab continuum in prevention and recovery
- Vision and Health Seminar
- What Vision Rehab Can Do for You (Low-vision 3)

Health education inclusion for uninsured/underinsured populations

Casa Colina provides health education that is relevant for its defined community, persons with or at risk of disability, in ways that the education can be accessed. For instance, in situations where there is a fee that might be a barrier to access for uninsured / underinsured populations, Casa Colina typically provides and advertises scholarship opportunities

2.10 Other direct aid to patients and families

(With specific focus on vulnerable populations) For persons who are low income, uninsured, and/or underinsured, Casa Colina provides financial assistance (charity care) through its financial assistance policies (see section 1.00). Casa Colina Outdoor Adventures provides scholarships to individual participants in addition to a general subsidy of all activities, however this function happens outside the Hospital proper and therefore is not accounted for as a Hospital community benefit. Similarly, the contributions to individual patients at the Transitional Living Center are also outside the Hospital proper.

Casa Colina owns six suburban homes on streets adjacent to the main campus in Pomona. One of these homes is a long-term residential facility for adults with intellectual and/or developmental disabilities, a part of Padua Village, a non-hospital operating entity of Casa Colina. The other homes are used for short-term rentals for families of patients who live at some distance but want to be close by during the rehabilitation process. These homes are managed by the Facilities department of the Hospital and are rented at a charge of \$1500 per month. For some families for whom this would be a great burden, but whom the treatment team would like to have near by, Casa Colina discounts the rental charge on a sliding scale from 0% to 100%. In FYE 2014 the discounts totaled \$28,050 and assisted 27 families.

Casa Colina also has contributed wheelchairs and wheelchair repair parts to organizations that make them available for free to those who are in need. In FY 2014 the total amount of these donations were \$2,200, supplying 10 wheelchairs.

2.11 Cultural and linguistic competence

Casa Colina enjoys cultural and linguistic diversity in its workforce and achieves cultural competence on a functional, daily basis principally by creating an environment among all staff members where diversity is accepted and accommodated. This creates a cultural and linguistically rich environment for working with patients and their needs.

For times when a staff member fluent in a particular language is not available, Casa Colina subscribes to a telephonic 24/7 translation service called Language Line to ensure that any language can be translated at any time. The cost for the subscription and fees for this service in FYE 2014 were \$9,078 and served 151 instances of translation needs.

2.12 Information and referral

Open line to nurse liaisons and clinicians for referral information.

Phone and email requests for information about rehabilitation issues come to Casa Colina from the region and all over the United States. Casa Colina staff takes time to assist these people with their questions about services available in their areas and/or explanations of the levels and settings of care that might be appropriate for their consideration, with the caveat that they need to make these decisions with the consultation of their own primary care physicians. It is estimated that there are 1,300 phone and email inquiries of this type in FY 2014. Expenses for this activity in were estimated at \$7,808, at an average cost of \$6.00 per interchange.

2.13 Treatment delivered through community partners

Children's Services has been providing treatment off site, at the locations of community partners, for many years. Most of these arrangements are by contract with school systems or other social service providers such as the LeRoy Haynes Center, where physical therapy, occupational therapy and speech therapy are offered by Casa Colina staff; and city government agencies such as La Verne in whose facilities the Teen Scene (autism) program operates. Through a joint venture with San Antonio Community Hospital, Casa Colina also manages the rehabilitation services at all of their sites both in their hospital in Rancho Cucamonga and at off-site outpatient locations. These services are all part of Casa Colina extending its benefit of expertise in rehabilitation and medicine to the community, but there were no unreimbursed costs associated with these programs.

2.14 Community preventive health and wellness programs

Distinct from support groups, diagnostic assistance (free screenings), and therapy treatments, Casa Colina also addresses its population's need for maintenance of health and wellness through programs aimed at extending the gains made in therapy by continuing self-directed programs of exercise and/or implementation of newly acquired skills. These programs are populated by former patients and community members with disabilities and are conducted with the oversight of therapists. There is sometimes a nominal monthly fee for "membership" to participate, but the programs also need to be subsidized by Casa Colina. The unreimbursed cost of these programs in FYE 2014 was \$71,853. These programs provided more than 16,202 participant visits in FYE 2014 and included these single and repeating events:

- Cogni-Fit program / Maintain cognitive fitness (2)
- Assisted Fitness Program
- Community Land Fitness Program
- Community Pool Fitness Program
- Fibromyalgia Small Group
- No Boundaries / SCI Fitness Program
- Parkinson's Group
- Rehabilitation through Golf
- Traveling with a Disability (MS) for Pasadena MS Support Group
- Free From Falls program for National MS Society
- Taylor Hall Claremont Health Fair - Balance Counseling
- Irwindale Senior Center Health Fair - Balance Counseling

3.00 Community Benefits Operations

3.01 Dedicated staff for Community Benefits operations

In FYE 2014 Casa Colina continued using dedicated staff to oversee and facilitate the community benefits effort, housed in the Community Benefits Department. The cost of operation of this department and the dedicated staff was \$127,490.

In addition the direction of the community benefits efforts is overseen and advised by the Community Benefits Committee, a committee of Casa Colina Hospital that meets twice a year. The Committee is composed of community members, board members, persons with disabilities, and staff members, and currently consists of 7 individuals. The committee serves as the direct liaison to the Board of Directors and the community on an on-going basis, reviewing and developing plans and direction for the community benefit effort, and interpreting community needs. The Board members currently participating are Mary Lou Jensen, Robert Balzer, Frank Alvarez, Donald Driftmier and (ex officio) Dr. Felice Loverso, the CEO and President.

3.02. Community Benefits Department, operational expenses

During this year many operational costs of providing community benefits were posted directly to the department as a way of reducing the cost of tracking them through many departments' functions. This included newspaper advertising and other outreach for community benefit events that were not tracked elsewhere (i.e., in the budget of a specific educational event). The *Community Health Needs Assessment* was commissioned for FY 2015 and is currently under way. Preliminary fees were budgeted and paid in FYE 2014, but the balance will appear as a budget item in FYE 2015. In addition, software was acquired in this year to assist in the collection of data relevant to community benefits reporting (*CBTracker* from the Michigan Health Association). The maintenance fee for this software will become a continuing expense. The total for the Community Benefits Department operational expenses was \$112,527.

4.00 Health Professions Education

4.01 Physician education and training

Regularly scheduled dinner meetings of the Medical Directors of the Physician Clinics are a venue to discuss and resolve operational issues of the clinics, but also frequently become times for the sharing of technical information and integrating frames of reference from the represented specialties. These meetings happen monthly with the participation of the CEO, the Administrator of Outpatient Services, and an average of 13 community-based specialist physicians. The expenses for these meetings were not tracked in FYE 2014 for this report. In addition physicians make presentations to all staff, community members, and community professionals, which are detailed elsewhere.

In FYE 2014 Casa Colina hosted the following educational arrangements for physicians:

- One Research Fellowship at UCLA in Neuroscience/Neurosurgery for a junior faculty member. The unreimbursed cost of providing this educational opportunity was \$105,000.

4.02 to 4.07 Overview

Casa Colina serves as a training site for more than 30 schools or departments in physical therapy, occupational therapy, speech and language therapy, neuropsychology, respiratory therapy, recreation therapy, pharmacy, physician assistant, nursing, medical coding, and other programs related to the professional and technical operation of a rehabilitation hospital and medical facility. In FYE 2014, 180 students participated in 45,348 hours of allied health internship, rotation, externship or practicum training at Casa Colina.

Community Benefit Expenses for Training Future Allied Health Professionals

Summary of Sections 4.02 to 4.07

Profession Type	Management Hours	Intern Hours	Intern Weeks	Persons	Comm. Benefit Expense (\$)	Average per Person (\$)
Nursing	2,781	17,248	112	106	172,470	1,627
PT, regular	1,675	12,960	324	38	95,626	2,517
PT, specialist residency	140	1,564	52	1	9,749	9,749
OT	342	7,380	184	20	19,737	987
Speech	80	708	16	1	3,489	3,489
Neuropsychology	1,119	5,488	390	14	74,253	5,303
TOTAL	6,137	45,348	1078	180	\$375,324	\$2,085

4.02 Nursing education and training

Casa Colina serves as a training site for the nursing program at Azusa Pacific University. In FYE 2014, 120 nursing students participated in 5,520 hours of internship training at Casa Colina, over 450 days. Casa Colina's personnel cost for mentoring and managing this program was \$173,262.

4.03 Allied health professions education and training, general statement /

Physical therapy education and training

Thirty-eight individuals developing careers as **physical therapists or physical therapy aides** served a cumulative 324 intern-weeks (12,960 hours) and required 1,675 hours of management and supervision aside from the mentoring and supervision of the therapy practice itself, for a personnel cost to Casa Colina of approximately \$95,626. In addition, Casa Colina is accredited to host an advanced physical therapy residency program. During the course of the year there was one (cumulative) resident who devoted 1,564 hours of service, requiring 140 hours of supervision at an expense of \$9,749. The total community benefit for physical therapy education was \$105,375, or an average Casa Colina investment of \$2,702 in each student's future.

4.04 Occupational therapy education and training

Twenty individuals developing careers as **occupational therapists or occupational therapy aides** served a cumulative 184 intern-weeks (7,380 hours) and required 342 hours of management and supervision aside from the mentoring and supervision of the therapy practice

itself, for a net personnel cost to Casa Colina of approximately \$19,737, or an average Casa Colina investment of \$987 in each student's future.

4.05 Speech pathology education and training

One individual who was developing a career in **speech pathology** served a cumulative 16 weeks (708 hours) and required 80 hours of management and supervision aside from the mentoring and supervision of the therapy practice itself, for a personnel cost to Casa Colina of approximately \$3,489 as an investment in that person's future career.

4.06 Neuropsychology education and training

Fourteen individuals who were developing careers in **neuropsychology** served a cumulative 390 weeks (5,488 hours) and required 1,119 hours of management and supervision aside from the mentoring and supervision of the therapy practice itself, for a personnel cost to Casa Colina of approximately \$74,253, an average investment of \$5,303 in each student's future.

4.07 Therapeutic recreation education and training

With the dislocation caused by the hiatus of the Outdoor Adventure program in FYE 2013 and the necessity to train its own new staff, Casa Colina was not able to host Therapeutic Recreation interns in FYE 2014. However, it did accommodate one student observer at an unreimbursed cost of \$51.

4.08 Education events for community health professionals

Healthcare professionals and students from the community and Casa Colina staff made approximately 1,121 visits to allied health (PT, OT, Speech, etc.) training programs and educational events at Casa Colina Hospital or other locations facilitated by Casa Colina in 29 separate sessions. There was a (net) cost to Casa Colina of \$20,270. Some of these groups or individuals made honorarium donations or paid other participant fees that have been subtracted from the total cost of providing these services to determine this net cost.

4.09 Audiology education and training

In FY 2014 Casa Colina hosted students of Audiology for observation opportunities but not for formal internship programs. The cost of providing these educational opportunities was not quantified.

5.00 Subsidized health services

This Report has already described the Free Care program (1.01) and the cost to cover losses on care provided to Medicare/Medicaid patients (1.02). The Board of Casa Colina has also determined that certain clinical programs or activities are of such value to patients and members of the community that they need to be sustained in spite of known potential for financial losses. In particular there are three "Signature Programs" that have been recognized in this respect for many years: Outdoor Adventures, the Padua Village residential homes and Children's Services. Both Outdoor Adventures and the Padua Village homes are not within the Hospital corporation so they are not included in the Hospital's community benefits tabulation. However, the subsidies, supplied by Casa Colina Foundation from historic and current fundraising, are community benefits and are noted separately in the tabulation. Children's Services, which is within the

Hospital, also benefited from this type of fundraising and support from operational reserves. Other programs as listed were subsidized directly from operation reserves.

5.01 Senior Evaluation Program, Team 105

The Senior Evaluation Program (SEP), which helps seniors define capabilities and target areas of disability that have potential for remediation, used \$59,271 in subsidy in FYE 2014, serving 34 individuals.

5.03 Children's Services, Teams 118-126

Children's Services as a whole is sustained on the basis of a Board-designated annual subsidy which comes from fundraising, grants and operational reserves. The amount of that subsidy in FYE 2014 was \$769,315, an 8.5% reduction from FYE 2013. When pediatric patients seen in all campus-based programs are included, 1,147 children received services in FYE 2014.

5.04 Sports Medicine, Team 173

The Sports Medicine Program (distinct from the Free Sports Injury screenings) used \$7,443 in subsidy in FYE 2014.

5.05 Outdoor Adventures including Land Meets Sea Sports Camp, Team 694

Outdoor Adventures is a community-oriented program to assist people with disabilities in effective re-entry into community and family life by providing challenging outdoor excursions in a therapeutic and intentional context. This program is not supported by insurance payments or government sources (MediCare, Medi-Cal, Regional Centers, CSS, etc.). In order to keep participation fees low enough to be affordable to persons with disabilities, who are overwhelmingly on limited, fixed incomes, the program as a whole has historically been subsidized by about 60% of the actual cost of every trip. These funds are raised on an annual and continuing basis through events and solicitations. Outdoor Adventures does not operate under the corporate umbrella of Casa Colina Hospital, but its services are an extension of the continuum of care whose base is in hospital services. The subsidy to sustain this program for FYE 2014 was \$168,530. On average, each of the 320 trip participations were subsidized on an average at \$527.

5.06 Padua Homes, Teams 410-413

Padua Village is a long-term residential program for adults with intellectual and/or developmental disabilities, with group homes located in Claremont and Pomona. It operates as a separate non-profit corporation from Casa Colina Hospital and uses a subsidy from historic and current fund raising to continue to provide its service to the members of the community who are its residents. In FYE 2014 that subsidy was \$485,795.

5.12 Wounded Warrior Fund, including family and support services

In 2003 it became evident that Traumatic Brain Injury (TBI) would be the signature wound for United States military personnel in the Iraq/Afghanistan wars. It was also understood that this was a relatively new diagnosis in terms of the volume of patients needing rehabilitation at Department of Defense and Veterans Administration medical facilities. As Casa Colina already had state-of-the-art expertise, Casa Colina's Board of Directors and management committed Casa Colina to providing rehabilitation services to appropriate military patients with TBI, to produce optimum outcomes to the best of our abilities, whether or not all the services were

reimbursed. Casa Colina established a Wounded Warrior program to be the organizational clearing house for this effort. Grant funding was acquired and, as news of the work Casa Colina was doing with military began to be made public, additional donations came earmarked for this purpose. Although the bulk of those funds has been expended, Casa Colina continues to see new military patients and follow through with former patients and participants in the Survive and Thrive program held in October 2009. In FYE 2014, \$368 of these special funds was expended on patient care services through Casa Colina Hospital.

6.00 Research

Casa Colina is not directly affiliated as a teaching hospital with a medical school or university. However, for more than 40 years it has sponsored an aggressive, independent research program and has collaborated with many medical and academic institutions, encouraging and sponsoring research about rehabilitation techniques, efficacy of models of care, outcomes measurement and health policy research. That tradition continues today with independent research, as part of multi-site research projects, as an incubator for young therapist-researchers, in evaluation of programs and innovations, and as a location for collaborative research projects.

6.01 Dedicated research department and staff

The Research Institute at Casa Colina has a full-time director, Emily Rosario, Ph.D., who is a research scientist. Her responsibilities include both designing and implementing research projects as the Principal Investigator and serving as a mentor to other staff who are initiating research projects. The Institute is housed in Casa Colina Hospital. The dedicated and part-time staff for this department, and dedicated operational expenses in FYE 2014 were \$148,558. There is significant diversity of staff working on research projects within Casa Colina including Social work, Physical Therapy, Occupational Therapy, Speech Pathology, physicians specializing in Physical Medicine and Rehabilitation, physicians specializing in Neurology, and Neuropsychologists. In addition there are other working on collaborative research projects at other facilities such as University of Southern California, University of La Verne, Western University of Health Sciences, California Institute of Technology, University of California Los Angeles and others. In FYE 2015, soon after the submission of this report, Casa Colina will have hired a second full-time Ph.D.- level researcher to supplement this work.

6.02 Research projects

The Casa Colina research program encompasses studies and investigations whose goal is to create generalizable knowledge particularly with respect to rehabilitation issues and diagnoses, and make it available to health care professionals and the public. Research interests include:

- Knowledge about underlying biological mechanisms of health and disease,
- Principles affecting health or illness,
- Evaluation of the efficacy or safety of interventions such as studies of therapeutic protocols, health outcomes and effectiveness,
- And behavioral or sociological studies related to health, delivery of care or prevention.

Research activities also include communication of findings and observations, including publication and conference presentations. The direct expenses for these research projects at Casa Colina Hospital in FYE 2014 that were not accounted elsewhere were \$14,471.

The continuing and new research projects at Casa Colina in FY 2014 included these topics:

- The effect of hyperbaric oxygen therapy on functional impairments caused by ischemic stroke
- Use of a Patient Navigator to assist individuals with brain injury to make a better transition to living with family and in the community
- Why falls occur among hospital patients and how they can be avoided
- The outcomes of rehabilitation programs and their usefulness in patients' lives
- Relationship of grip strength to writing capabilities in children
- Study of audiology services for children with atresia
- Traumatic brain injury and pituitary hormones
- Healthy Aging Practices and persons aging with developmental/intellectual disabilities, carrying forward a previous county-wide nurse practitioner health care assessment project (with grant funding from UniHealth Foundation)
- Healthy Aging Practices and persons aging with developmental/intellectual disabilities / Intervention for health promotion activities at Padua Village Homes (with grant funding from UniHealth Foundation)
- I-Care study (collaborative site): Interdisciplinary Comprehensive Arm Rehabilitation Evaluation (I-Care) Stroke Initiative
- Does an electronic medical record save time? The first part of the study will measure the time it takes to use a hard-copy medical record. This is a preliminary base-line study that will be used as a comparison with a time study to be done after an electronic medical record is implemented in the next year.
- Participation in the national research working group of the American Medical Rehabilitation Providers Association.

The following conference acceptances and presentations at national and international levels were made in FY 2014:

1. Dausilio J., Rosario, E.R., Kaplan, S. Predicting Fall Risk in Acute Rehabilitation Facilities. Association of Rehabilitation Nursing (2014) – Oral Presentation
2. Attaway, J., Sendor, C., Stone, C., Rosario, E.R. The Effect Of Amplification On Speech And Language Abilities In Children With Atresia. CA Academy of Audiology Conference (2014) – Oral Presentation
3. Dausilio J., **Rosario, E.R.**, Kaplan, S. Predicting Fall Risk in Acute Rehabilitation Facilities. Association of Rehabilitation Nursing (2013) – *oral presentation*
4. Attaway, J., Sendor, C., Stone, C., **Rosario, E.R.** The Effect Of Amplification On Speech And Language Abilities In Children With Atresia. 4th International Symposium on Bone Conduction Hearing - Craniofacial osseo-integration (2013) – oral presentation
5. Rosario E.R., Espinoza, L., Bustos, M., Scudder, B. Patient Navigation for Traumatic Brain Injury. American Congress for Rehabilitation Medicine (ACRM) (2014) – Poster Presentation

6. Kaplan, S., Rosario, ER. Inpatient Rehabilitation Facility Admission Outcomes Specific for Patients with Stroke Predict Community Discharge. American Congress for Rehabilitation Medicine (ACRM) (2014) – poster presentation
7. Johnson, S., Keyan, Z., Rosario, E.R., Measuring the efficacy of aquatic therapy for low back pain. NEXT Conference and Exposition, American Physical Therapy Association (2014) – poster presentation
8. Rosario E.R., Espinoza, L., Bustos, M., Scudder, B. Patient Navigation for Traumatic Brain Injury. 10th International Brain Injury Conference San Francisco CA (2014) – poster presentation
9. Espinoza, L., Scudder, B., Bustos, M., Rosario E.R., Patient Navigation for Traumatic Brain Injury. North America Brain Injury Society (2013) – poster presentation
10. **Rosario, E.R.**, Espinoza, L., Scudder, B. Hypothalamic pituitary dysfunction following traumatic brain injury. Society for Neuroscience (2013) – poster presentation
11. Sendor, C., Attaway, J., Stone, C., **Rosario, E.R.** The Effect Of Amplification On Speech And Language Abilities In Children With Atresia. CSHA Annual Conference (2013) – *poster presentation*
12. Espinoza, L., Scudder, B., Bustos, M., **Rosario E.R.**, Patient Navigation for Traumatic Brain Injury. North America Brain Injury Society (2013) – poster presentation
13. Whiting D., Huskey, D., **Rosario E.R.**, Metyas, S. Effectiveness of Interdisciplinary program for Fibromyalgia. American Congress of Rheumatology (2013) – poster presentation
14. Johnson, S., Keyan, Z., **Rosario, E.R.**, Measuring the efficacy of aquatic therapy for low back pain. California Physical Therapy Association (2013) – poster presentation
15. Keilson, M., **Rosario, E.R.** Pinch Strength and its Relationship to Penmanship and ADLs. Occupational Therapy (2013) – oral presentation

The following manuscripts were accepted for publication in FY 2014. They included publication in the #2 ranked rehabilitation journal, the *Journal of Head Trauma Rehabilitation*.

1. Begum AN, Cunha C, Sidhu H, Alkam T, Scolnick J, Rosario ER, Ethell DW. (2014) Women with the Alzheimer's risk marker ApoE4 lose Abeta specific CD4+ T cells 10 - 20 years before men. *Translational Psychiatry In press*.
2. Rosario ER, Kaplan SE, Khonsari S, Patterson D. (2014) Predicting and Assessing Fall Risk in an Acute Inpatient Rehabilitation Facility. *Rehabilitation Nursing* 39(2): 86-93.

3. Rosario, E.R., Bustos, M.R., Moore, C. (2013) Hypothalamic Pituitary Dysfunction Following Traumatic Brain Injury. *Social Care and Neurodisability* 4 (3/4).
4. Rosario, E.R., Aqeel, R., Brown, M.A., Sanchez, G., Moore, C., Patterson, D. (2013) Hypothalamic-pituitary dysfunction following traumatic brain injury affects functional improvement during acute inpatient rehabilitation. *Journal of Head Trauma Rehabilitation* 28 (5): 390-6.
5. Hahn, J.E., Aronow, H.U., Rosario, E.R., Guenther, N. (2013) Multidimensional health risk appraisal among adults aging with acquired disabilities. *Disability and Health Journal* 6 (3): 195-203.

6.03 Institutional Review Board (IRB) operations

An IRB is an essential part of a medical organization's research efforts. Casa Colina maintains its own federally-sanctioned IRB to monitor and oversee the role of human subjects in research projects. The IRB has monthly meetings. The Director of the Research Institute is also the Chairman of the IRB. There are six other members of the IRB including a physician, a pharmacist, the Chief Nursing Officer, a neuropsychologist, a member of the community, and the Corporate Compliance / Accreditation / Licensure Officer. During the year the IRB reviewed projects on a quarterly basis, and more frequently when needed. The unreimbursed expense of the IRB in FYE 2014 was \$6,144.

7.00 Support of community groups and individuals

7.01 Contributions to community individuals and nonprofit organizations

As a part of coalition and capacity building for community organizations pertaining to health care and the needs of persons with or at risk of disability, the environment of the community in general and being a responsible, engaged corporate member of the community, Casa Colina sponsors or participates in events for a range of other charitable, non-profit and educational organizations. During FYE 2014 Casa Colina as an organization made 36 significant contributions to organizations through direct contributions and sponsorships of events. This does not include memberships in Chambers of Commerce, which were deleted from this tally. These community benefit sponsorships totaled \$56,000. They included these organizations:

- ALS Association
- Brain Injury Alliance
- Bright Prospects
- Children's Fund, Inland Empire
- City of Claremont
- Creative Underground/Six Strings Workshop
- Diamond Ranch High School
- Kiwanis Club of Upland
- Loma Linda University Medical Center / Big Hearts for Little Hearts Desert Guild
- Los Angeles County Fair / Learning Center
- Megan's Wings
- Methodist Hospital Foundation / Arcadia
- Natalie Gwen Bradhurst, charity run sponsorship

- Pomona Valley Hospital Medical Center Foundation
- Run for the Wall
- San Antonio Community Hospital Foundation
- San Gabriel Valley
- Tony Lara, wheelchair athlete sponsorship
- UCLA Foundation / Neurosurgery Visionary Ball
- University of La Verne / Scholarship Gala
- VFW Ladies Auxiliary
- Western University of Health Sciences
- White Heart Foundation / Veterans Assistance

7.02 Cost of Fundraising for Community Benefits efforts

The cost of Casa Colina's grant writing program and event-based fund raising to support community benefits efforts directly are seen as community benefit expenses. The total for FYE 2014 was \$181,660 for the pursuit of funds to support these community benefit efforts. This includes salaries and operational expenses for grant writing and grant fulfillment, and the expenses for fund raising events directed at community benefits purposes such as free and subsidized services to patients and families.

7.03 Community building through outreach to and collaboration with community organizations

Casa Colina, as one of the larger non-profits in the area, has facilities and people on staff with particular expertise that many smaller non-profits do not have. In addition to direct support through sponsorship, as listed above, and as part of its own citizenship in the non-profit community, Casa Colina makes these available to other organizations, particularly in cases where their overall mission or particular goal is aligned with Casa Colina's mission of service to persons with our at risk of disability. Community benefit in this sense was provided in forms ranging from equipment, technical assistance, and the use of the classroom and (A/V) equipment in the Tamkin Education Center to providing people with special expertise to collaborate on community-wide projects, planning and advocacy. In FY 2014 these were provided at a cost of \$14,072, and these efforts impacted 876 people. The subjects of these meeting included:

- Chino Hills High School Health and Science Academy Advisory Board (series of meetings)
- Collaboration on Transition to Adulthood for Adolescents on the Autism Spectrum (parent support group and one with the planning group)
- Hosted meeting of HR Professional Association at Casa Colina
- LICA (Local Interagency Collaboration Association) meeting/ Autism presentation by Dr. Bauman
- LICA meetings/ Collaborative re early intervention for children w ASD (monthly, year-round)
- Meeting to address filling gaps in education services for adults with disabilities
- Meeting to promote idea of diagnostic clinic for children at risk of ASD
- OT Collaborative / for children with ASD (two meetings)
- Planning Dinner with Director of Autism Society of Inland Empire
- Training for personnel of San Gabriel Valley Parks and Rec Relative to persons with disabilities
- Vendor Advisory Board, San Gabriel/Pomona Regional Center (monthly meetings)
- Visit to Westmoreland School for collaborative consultation

Casa Colina staff members participate in many local organizations that have individuals with disproportionate unmet healthcare needs (DUHN) as their focus. These range from organizations that focus on Downs Syndrome, autism, spinal cord injury, brain injury, MS, Parkinson's, and

many other diagnostic and disability related areas. Staff time and expenses devoted to these efforts are included in the total above. Community and health-care related organizations with which Casa Colina personnel worked included these:

- Californian Physical Therapy Association; Legislation Day
- Chino Hills High School Science Advisory Board
- LICA (Local Interagency Council Association);
 - Meetings for collaboration of early intervention professionals
- San Gabriel/Pomona Regional Center –
 - Community Relations Committee
 - Vendor Advisory Committee (Regional Center VAC)
- Professional Nursing Society
- Foothill Autism Alliance
- EII Group (Early Identification and Intervention for Autism)
- Human Resources Professionals Association
- Occupational Therapy Collaborative
- Mothers group to provide autism education
- City of La Verne Inclusion Advisory Committee
- New Day Conference (options for life after public education for those with disabilities)
- Local Interagency Council Association

Among these involvements were:

- Cindy Sendor, Director of Children's Services, and Susan Stroebel, family liaison at Children's Services, continue as Casa Colina's representatives to the San Gabriel Pomona Regional Center Vendor Advisory and Community Relations Committees, serving as a conduit for information relative to services and needs among Casa Colina, the Regional Center and the community.
- Cindy Sendor and Susan Stroebel continue as Casa Colina's representatives to the LICA Early Intervention Collaborative, a monthly meeting of all Early Intervention providers that is an opportunity for training and a forum for the exchange of information, yielding the ability to be more responsive to families' and Regional Centers' needs.
- Susan Stroebel continues as the Casa Colina representative to the Early Identification and Intervention Group (EII Group). This is a regional consortium of provider and advocacy agencies from across Los Angeles County concerned with appropriate early identification and intervention care for children with developmental delay in general and autism spectrum disorders in particular. The group meets monthly at various locations to share information, evaluate legislation pertinent to children with developmental delay, and make recommendations to government and other agencies about policy.

8.01 Support of regional, state and national advocacy organizations

Casa Colina staff members participate in many regional and national organizations that have individuals with disproportionate unmet healthcare needs (DUHN) as their focus, in this case persons with or at risk of disability. As a part of coalition and capacity building at this regional and national level, and advocating through these organizations for improved health for persons with or at risk of disabilities, Casa Colina supports organizations and sponsors events for a range of other charitable, non-profit and educational entities. The goal is to build effective

organizations for teaching, advocacy, support of research, and recognition of the needs of persons with disabilities.

Support of organizations and activities at this regional and state level falls outside the federal definitions of community benefit as expressed in the IRS Form 990 Schedule H instructions, yet fall inside the definition of community as interpreted from the ASCBA guide as recommended by the State of California⁴. For this OSHPD report, they are included. In FYE 2014 the expenses relating to the support of these organizations were \$13,000. The organizations included the following:

- American Medical Rehabilitation Providers Association (AMRPA)
- American Society for Healthcare Human Resources Administration
- Medical Development Specialists

Staff time loaned and assistance donated to national organizations

Many of the issues that are critical for the health and well-being of the population that Casa Colina serves have aspects that are impacted by decisions and priorities set at a regional and national level. Therefore, as a steward of their interests, it is necessary for Casa Colina to be engaged and pro-active in organizations that have a voice in those discussions.

- Dr. Loverso, President and CEO of Casa Colina, has been a member of the Board of Directors of the American Medical Rehabilitation Providers Association (AMRPA) since 1999. The AMRPA is the national trade organization for medical rehabilitation providers, with offices in Washington, DC. From 2002 to 2005 Dr. Loverso served as President. He has also served as Chair of the Data Committee, the Veterans Affairs Committee and with several other working committees.
- Dr. Emily Rosario, the Director of Casa Colina's Research Institute, serves as a member of the AMRPA Research Committee.
- Dr. Loverso has served as a member of the Board of Directors of the California Brain Injury Association.
- Stephanie Kaplan, DPT, Director of Therapy Services for Casa Colina, is an active board and committee member at the State level in the Association for Physical Therapy, working on policy and advocacy issues for that discipline.

The total expense for this community health improvement advocacy participation, including travel, lodging, and time, was not quantified separately for FYE 2014.

9.00 Non-quantifiable benefits

It continues to be the case that the recent history of health care in California shows that well-regarded hospitals have been forced to close. In the case of a specialty hospital unique in its region, if that were to happen to Casa Colina Hospital, there would not be a comparable replacement or alternative for services. In that Casa Colina by definition serves a vulnerable

⁴ *Advancing the State of the Art in Community Benefit: A User's Guide to Excellence and Accountability* (ASACB)., Public Health Institute, November 2004

population with, arguably, disproportionate unmet healthcare needs (DUHN), its continued existence carries a Community Benefit aspect in its own right.

10.00 ASACB-defined public interest initiatives

The Public Health Institute ASACB⁵ partners regard the following activities as important demonstrations of a nonprofit hospital's support of activities in the public interest, but they also agree that there are legitimate questions about including them in the financial accounting of a hospital's community benefit contributions. They also recognize that there is a need for increased public awareness of hospital expenditures and efforts in these areas. They suggest that these resource allocations be compiled and reported in a separate narrative portion of the community benefit report, and not include them in the financial totals of hospital community benefit contributions (ASACB, p.33). Therefore this section is included as an Addendum to the present report.

10.01 Service improvements

Casa Colina continues to develop its services. In FYE 2014 these developments were financed out of operational reserves, fundraising, and a new bond issue. The Board of Directors has committed more than \$7,000,000 in operational reserves to these and other development projects in the current period of several years, however, the value of these activities in FYE 2014 is not separately quantified.

- In FYE 2014 Casa Colina Hospital's satellite outpatient therapy facility in Azusa continued to grow in volume and in sustainability. It provides physical, occupational, and speech therapy modalities; specialization in hand therapy; neuropsychology; specialist physician services and a free Sports Medicine screening clinic one evening a week. It is across the street from Azusa Pacific University (APU) and serves as an internship site for Allied Health students from APU.
- In FYE 2014 Casa Colina moved ahead on the work of the contract signed FYE 2013 with Siemens America to implement a comprehensive, entity-wide electronic medical record (EMR). It is a commitment that over a period of years will be in excess of \$8,000,000. Some elements of the system have been brought on-line slowly over the last few years, but in FYE 2014 and 2015 the major work of definition, design, installation and training has and will occur with a "go live" date of January 2015 necessary to be prepared for the opening of the new 31-bed medical/surgical service in April 2015. As many other institutions have experienced disastrous results by not entering this major cultural change with caution (Cedars Sinai installed a system in the 2002 and had to abandon it, losing \$34 million in the process), Casa Colina has proceeded with deliberation.
- Casa Colina has completed a 24,000 square foot Medical Office Building to attract and retain more primary care and specialist physicians to the community, and give them a place to practice in proximity to Casa Colina's continuum of support services. This project was financed internally with the support of community physicians.
- Casa Colina commenced construction in FY 2014 of a 38,000 square foot addition to Casa Colina Hospital. This will add 31 medical/surgical beds, three operating rooms and a procedure room. The addition will change the nature of Casa Colina Hospital from being a

⁵ *Advancing the State of the Art in Community Benefit*, cited above.

specialized rehabilitation hospital to being a medical/surgical hospital of 31 beds with a rehabilitation unit of 68 beds. Completion of construction is expected in January 2015 and, allowing time for licensing and regulatory review, it is expected that the new hospital will accept its first patients in April 2015. This project was financed from internal operational reserves, grants, fund-raising, and a bond issue.

10.02 Disaster preparedness

Casa Colina Hospital has an internal disaster preparedness program and participates in regional, county and state-wide preparedness exercises. As the only fully-seismically-upgraded medical facility in the region, Casa Colina feels a responsibility to be a solid partner in these exercises particularly in relation to the potential for a large earthquake in the near future and the potential that Casa Colina would be a structurally safe haven that many people would come to. The cost of planning, preparing, and conducting drills in FY 2014 was not separately quantified.

10.03 Workplace enhancement of diversity

Casa Colina honors and respects the diversity of Southern California, and has since its inception in 1936 as evidenced by photographs of Frances Eleanor Smith, the founder, with diverse patients and staff from that period. Currently Casa Colina hires on the basis of expertise and potential for the candidate to do the best job, and advances people from within on the same basis. Within that context, Casa Colina exists in the highly diverse environment of Southern California and the composition of the staff strongly reflects that diversity. As stated in the Mission Statement with reference to the goals for patients, “an environment that recognizes their uniqueness, dignity and self-esteem,” the same is applied with reference to every staff member. Casa Colina’s commitment to working with students who also come from this diverse environment is another practical way that Casa Colina implements the goal of giving people of all backgrounds the tools to be successful in health care careers, whether at Casa Colina or elsewhere. The value of this activity is not quantified.

10.04 External funds leveraged: Grants and donations secured to implement community benefit activities

Casa Colina Hospital and other Casa Colina entities received and/or made use of previously received grant awards and directed donations to implement projects that reflect community benefits. These included the following projects listed with the amounts expended in FYE 2014.

Source of funds / Funds marked (1) appear in the report above as Community Benefits in their appropriate category	Funds used at Casa Colina Hospital	Funds used at other Casa Colina entities	Use of funds
Adult Day Health Care designated funds from general donations (1)		\$ 679	Payment for program supplies for Adult Day Health Care from general donations with designation for Adult Day Health Care
California Communication Access Foundation	\$ 12,476		Transitional Living Center general operations
Charity care (1)	\$ 48,915		Free care funds used from designated donations (these were included in section 1.01).

Source of funds / Funds marked (1) appear in the report above as Community Benefits in their appropriate category	Funds used at Casa Colina Hospital	Funds used at other Casa Colina entities	Use of funds
Children's Services designated funds from general donations (1)	\$ 41,667		Partial payment toward Children's Services subsidy from general donation with designation for Children's Services
Children's Services designated funds from net of fund raising events (1)	\$ 8,333		Partial payment toward Children's Services subsidy from events fundraising with designation for Children's Services
David Loucks baseball Fund		\$ 936	Bequest restricted to providing patients and others excursions to baseball games
Morris/Levine Bequests (1)	\$ 0		Bequest restricted to providing patients access to hyperbaric oxygen therapy, wound care, stroke care, and associated research and program development
Neilsen Foundation 01	\$ 2,420		Assistive technology equipment grant
Outdoor Adventure designated funds from general donations		\$ 8,246	Partial payment toward Outdoor Adventures subsidy from general donation with designation for Outdoor Adventures
Outdoor Adventures designated funds from Weingart Foundation grant		\$2,102	Partial payment toward Outdoor Adventures subsidy from general donation with designation for Outdoor Adventures
Outdoor Adventures designated funds from Orange County Commiunity Foundation grant		\$5,000	Partial payment toward Outdoor Adventures subsidy from general donation with designation for Outdoor Adventures
Padua Village designated funds from general donations (1)		\$ 14,005	Partial payment toward Padua Village subsidy from general donation with designation for Padua Village
Padua Village designated funds from net of fund raising events (1)		\$ 209,368	Partial payment toward Padua Village subsidy from events fundraising with designation for Padua Village
Padua Village designated funds from memorials		\$ 11,164	Partial payment toward Padua Village subsidy from general donation with designation for Padua Village
San Manuel Band of Mission Indians Grant 01		\$15,000	Use of grant funds to subsidize specific excursions of Outdoor Adventures
PCV-VRM Seeds of Hope Foundation (unrestricted)	\$1,000		Use of funds for free and charity care
UniHealth Foundation 03		\$ 0	"Healthy aging for persons with an intellectual/development disability" grant
UniHealth Foundation 04	\$ 98,121		Electronic medical record implementation grant
UniHealth Foundation 05		\$ 49,696	Wellness intervention for persons with I/DD and advanced aging

Source of funds / Funds marked (1) appear in the report above as Community Benefits in their appropriate category	Funds used at Casa Colina Hospital	Funds used at other Casa Colina entities	Use of funds
Wounded Warriors (1)	\$368		Free care and other services for veterans with TBI from temporary restricted funds designated for the Wounded Warrior program.
SUB-TOTALS	\$ 213,300	\$ 316,196	
TOTAL		\$ 529,496	

10.05. Grants secured for other organizations/local groups by the Hospital.

There was no activity of this type in FY2014.

10.07 Funds raised at events

Casa Colina has an annual cycle of fund raising events. Most of these are targeted to raise funds for Signature Programs that are not under the umbrella of or specific to the Hospital such as the residential services at Padua Village or the community-based Outdoor Adventures program. Others support free care or general operating support. In total in FYE 2014 these events brought net proceeds to Casa Colina Hospital of \$207,962 and to all other parts of Casa Colina of \$280,272, for a combined total of \$488,234. The expenses to raise these funds is addressed in section 7.02 and the use of some of these funds is addressed in sections 5.03, 5.05, 5.06 and 5.12.

10.08 Financial value of volunteers who directly support Community Benefit activities.

Community Benefit related activities of volunteers were not documented distinct from other Volunteer Services activities in FYE 2014. However, in general, the activities of all volunteers are aimed at supporting the mission of Casa Colina, which in itself is directed at service to individuals with or at risk of disabilities, and therefore could be considered as Community Benefit activities. Additionally, the opportunity to volunteer can be considered a community benefit in itself, for both younger people who use volunteering as a stepping stone to employment and older people for whom it is an opportunity to give back to the community and be productive. In these senses the expense of operating the volunteer program and the financial benefit of the program would both be community benefit elements.

The total budget for the volunteer program in FYE 2014 was \$27,538. The total of volunteer hours was 25,110 for 165 active volunteers, the equivalent to the work of 12.1 full time employees. With a conservative valuation \$12 per hour plus fringe benefits, the value of that effort was \$397,742. The net benefit that the program brought to the community was \$370,204. It is also interesting to note that typically two-thirds of volunteers were younger than 30 years old, with the implication that they are using volunteering as part of their education or initial job advancement. Another 10% are 50 year old or more, with the implication that volunteering is giving them an outlet to be productive and participate in a social environment.

10.09 Other Benefits for Vulnerable Populations

10.091 Self help

Padua Village Homes is a residential service for adults with intellectual/developmental disabilities operated by Casa Colina, Inc., but separate from the Hospital. However, Casa Colina Hospital has established a special physician's clinic in the hospital's outpatient physician clinic system to monitor and assist with medical oversight especially with regards to issues of aging with a disability. A multi-year grant project to support this work was awarded March 2008 from the UniHealth Foundation. As well as supporting an intentional healthy aging program at Casa Colina's Padua Village Homes that is under the medical leadership of the dedicated Physician Clinic, the grant design also includes a research component that will investigate health-promotion activities and effectiveness among persons aging with a disability across Los Angeles County. A significant part of the Padua health intervention is self-help and self-regulation among the residents, and personal initiatives for health promotion among the residents' families and care givers.

10.093 Enrollment assistance

Casa Colina continues to assist patients with enrollment into health care funding programs when requested, as their needs change due to rehabilitation, recovery and employment status. The cost of this assistance is not tracked.

ATTACHMENTS

A. Casa Colina 2012 Community Benefit Health Needs Assessment Summary Report

B. Casa Colina 2012 Community Benefit Health Needs Assessment Supplement



**Casa Colina Hospital for Rehabilitative Medicine
2012 Community Health Needs Assessment**

Prepared for
Casa Colina Hospital for Rehabilitative Medicine
Pomona, California

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In Appreciation

Casa Colina wishes to express its appreciation to Nancy Guenther, Chair of the ODH TAKE ACTION Advisory Committee of the California Office of Public Health's Office on Disability and Health, for her assistance in making it possible for Casa Colina to recruit the members of the committee for the focus group, and making arrangements and introductions for the focus group to occur.

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Executive Summary

Casa Colina Hospital for Rehabilitative Medicine in Pomona, CA is a 68-bed acute licensed specialty hospital with additional services that include a outpatient rehabilitation, specialist physician clinics, outpatient pediatric rehabilitation, and a satellite outpatient rehabilitation unit in Azusa. As an institution focused on rehabilitative medicine, it considers the community it serves to be persons with disabilities or who are at risk of disabilities, and who can benefit from rehabilitation. This is the sense in which “community” is used throughout this Community Health Needs Assessment (CHNA) report. The general population base from which ~80% of Casa Colina’s patients are referred is a ~15 mile radius from the Casa Colina Pomona campus, comprising 17 cities in the 917xx zip codes with a total population of about 1.44 million people (US Census 2000).

Casa Colina Hospital commissioned the evaluation group from Claremont Graduate University’s Institute for Organizational and Program Evaluation Research to conduct the CHNA for 2012. To carry out this study, the evaluators administered a questionnaire both as a scripted phone interview and as a publicly available online survey and they conducted a focus group with industry professionals and experts from an advisory group to the California Office of Public Health’s Office on Disability and Health (ODH TAKE ACTION Advisory Committee, Nancy Guenther, Chairperson). The results of this CHNA follow closely the results CHNAs conducted since 1995.

Members of Casa Colina Hospital’s community report that most needs and concerns presented in the survey are very important. For most of the issues presented, “Very...” (Concerned or Important) is the most frequent response. Concern about “Health Getting Worse”, “Being Able to Receive Rehabilitation Services When Needed”, and “Receiving Basic

Healthcare Services” stand out as being of greater importance or concern than others. In particular, “Health Getting Worse” and “Being Able to Receive Rehabilitation Services When Needed” have stood out among the most important issues in the needs assessments for 2003, 2009, and the current study, for 2012. “Being Able to Work Full/Part Time”, “Counseling Services”, and “Having Equipment” have ranked low among the needs and concerns in the survey since the study conducted in 2003.

The intuitions and opinions of the focus group participants match up well with survey responses. Four suggestions emerged from the focus group, two of seemingly relatively low cost and two of potentially higher cost. While not providing a complete solution for the most important needs and concerns, these suggestions do have the potential to at least partially address some of the most important issues as well as some of the middle-ranked issues. The two easiest and relatively low cost recommendations are to create a “resource room” and conduct a very brief survey to ascertain what availability community members want or need. The resource room would be a place that patients (and perhaps other community members) could visit before or after appointments at Casa Colina Hospital’s various services to network with other persons who might be in similar situations and to find information about nearby free or low cost services. It was also recommended by the focus group participants that Casa Colina Hospital conduct a cost analysis of the other two suggestions: (1) making outpatient rehabilitation equipment open to community members with disabilities or at risk for disability and (2) implementing or expanding a “team care” approach. These are both areas that Casa Colina has already addressed⁶.

⁶ Casa Colina has a Fitness Program that gives community members the opportunity to use the outpatient services gym for self-directed maintenance regimens at a very small monthly fee. Also for a small fee, the therapy pools are available to members of the community for an aquatic exercise program that occurs three sessions a day, five days a week. This program hosts about 7,000 visits a year. Additionally, Casa Colina pioneered the treatment team model in the 1980’s and has used it system-wide since that time.

Background

Over the summer and early fall of 2011, evaluators from Claremont Graduate University's Institute for Organizational and Program Evaluation Research (IOPER) carried out the 2012 Community Benefit Needs Assessment for Casa Colina Hospital. The evaluation team concentrated on two foci: (1) existing needs and the needs and challenges likely to face the community in the near future, as identified in a focus group with members of ODH TAKE ACTION Advisory Committee and (2) the needs felt by members of the community served by Casa Colina, as identified through a questionnaire administered as an online survey through Casa Colina's website and as scripted telephone interviews with randomly selected patients treated at Casa Colina Hospital in the twelve months prior to the study. The focus group occurred October 12, 2011 and the surveys occurred between April and December 2011.

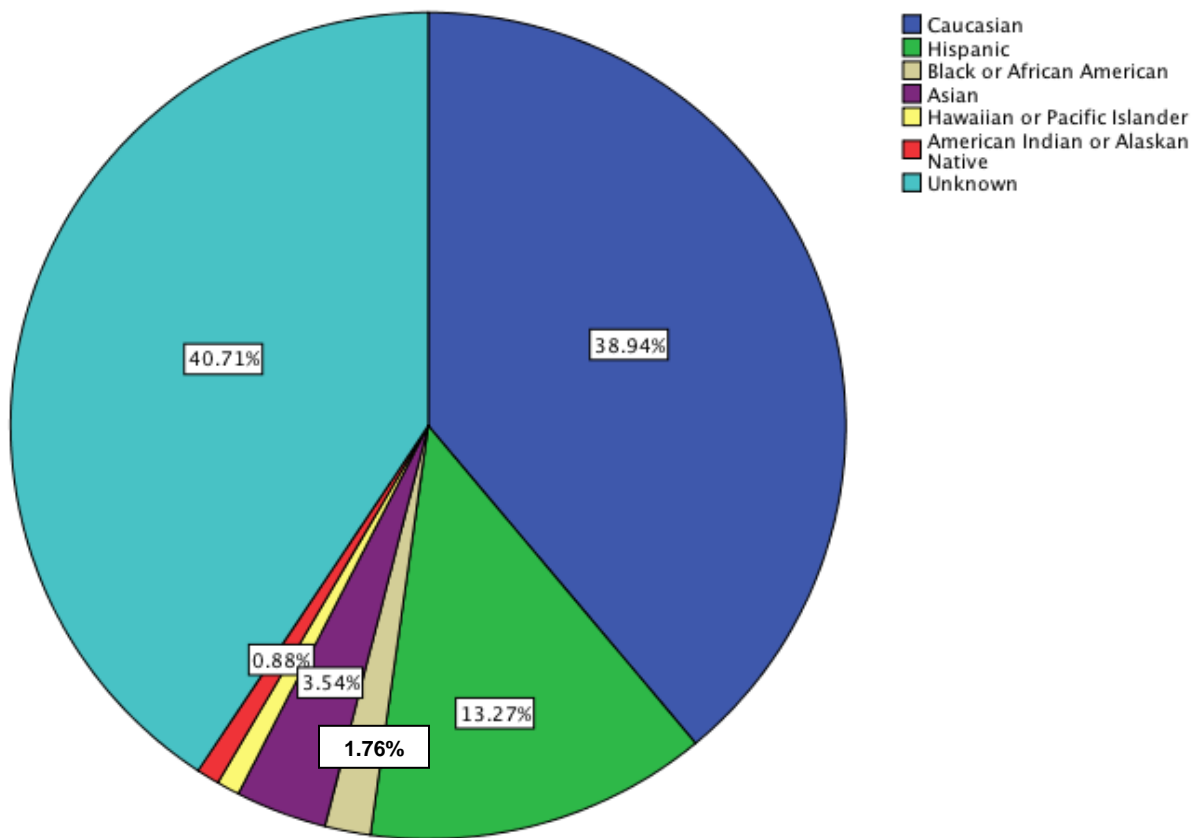
Participants

Focus Group. Five focus group participants were recruited from an advisory committee serving the California Office of Public Health's Office on Disability and Health. This advisory committee (ODH TAKE ACTION Advisory Committee) is composed of professionals from health sectors related to Casa Colina Hospital's mission (See Appendix A for a complete list of this committee's members.).

Survey. A total of 128 participants completed the survey (110 as scripted interviews and 18 online). Not all respondents who completed the survey answered every question, thus the *n* (number of participants) will vary for some items. Roughly the same number of men (49.6%) and women (50.4%) responded to the survey (*n* = 115). Caucasian participants represented the largest ethnicity with 38.9%, but more participants (40.7%, *n* = 113) reported that their ethnicity

was unknown. Hispanic participants were the next largest group (13.3%). Taken at face value, these demographics would seem to be not quite representative of the local area, where Hispanics and Latinos typically account for more than 13% of the population, but this may well be a result of the 40% reported unknown. Figure 1 displays the breakdown of reported ethnicity among participants in this study.

Figure 1. Ethnicity of Participants



Making clear comparative statements about ethnicity is made more difficult by the different ways these statistics are tracked, particularly in situations where “decline to state” is one of the allowed responses, as is the case with Casa Colina’s patient admissions and with this survey. Additionally, Census figures available state the Hispanic/Latino population separately from the 100% of the rest of the population. However, the table below gives a rough idea of the

comparison of the ethnicity makeup of the respondents to the survey, Casa Colina's patient mix, and the population from which that mix is drawn (~15-mile radius from the Pomona campus).

Table 1. Ethnicity of General Population, All Patients and Respondents (A)

Following Census Format ("Hispanic/Latino" listed separately).

	General population n = 1.24 million (US Census 2000) ⁷	Patients of Casa Colina Hospital, FY 2012 n = 2851 ⁸	Respondents to Survey n = 68 ⁹
White	59.0%	88.6%	84.6%
African-American	5.7%	6.2%	3.8%
Native American	0.8%	0.1%	1.9%
Asian	22.4%	4.8%	7.7%
Hawaiian/Pacific Islander	0.2%	0.3%	1.9%
Other / unknown / not stated	Not included	Not included	Not included
2 or more ethnic identifications	11.9%	Not tracked	Not tracked
TOTAL (N.B., rounding errors)	101.0%	100.0%	99.90%
Hispanic/Latino (separately)	44.5%	25.3%	22.4%

Table 2. Ethnicity of General Population, All Patients and Respondents (B)

This format includes "Hispanic/Latino" in the general count. "Other / unknown / not stated" are not included in this table. The "n" of each column shows only those people who self-identified with a specific ethnicity..

	General population n = 1.24 million (US Census 2000) ¹⁰	All patients of Casa Colina, FY 2012 n = 2851 ¹¹	Respondents to Survey n = 68 ¹²
White	32.7%	63.5%	65.7%
African-American	3.2%	6.1%	3.0%
Native American	0.5%	0.1%	1.5%
Asian	12.5%	4.8%	6.0%
Hawaiian/Pacific Islander	0.1%	0.2%	1.5%
Other / unknown / not stated	Not included	Not included	Not included
2 or more ethnic identifications	6.6%	Not tracked	Not tracked
Hispanic/Latino	44.5%	25.3%	22.4%
TOTAL (N.B., rounding errors)	100.10%	100.00%	100.10%

⁷ The n=1.24 million number represents all person with identified ethnicity. The total number of person was 1.44 million of whom 15% (216,000) were not specified with an ethnic identity.

⁸ The n=2851 number represents all patients who chose to self-identify. The total number of patients was 10,632 of whom 73.18% (7,781) did not choose to state ethnic identity.

⁹ The n=68 number represents all patients who chose to self-identify. The total number of respondents was 115 of whom 40.7% (47) did not choose to state ethnic identity.

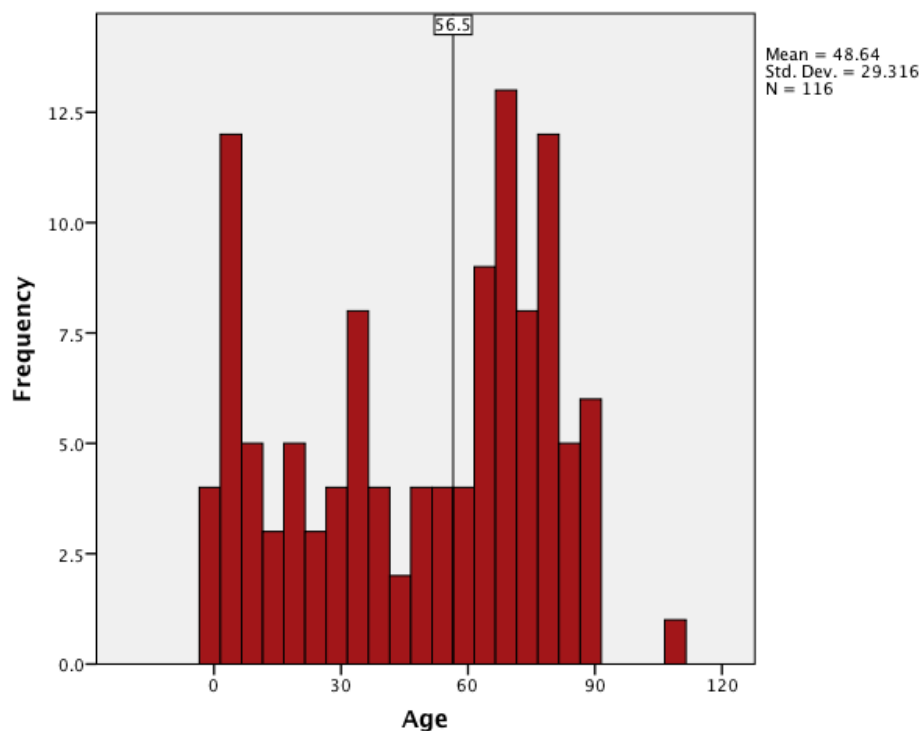
¹⁰ Hispanic/Latino proportion has been deleted from other categories on the basis of their percentages. In this Table the "Other / unknown / not stated" category has been deleted from totals and percentages.

¹¹ The n=2851 number represents all patients who chose to self-identify. The total number of patients was 10,632 of whom 73.18% (7,781) did not choose to state ethnic identity.

¹² The n=68 number represents all patients who chose to self-identify. The total number of respondents was 115 of whom 40.7% (47) did not choose to state ethnic identity.

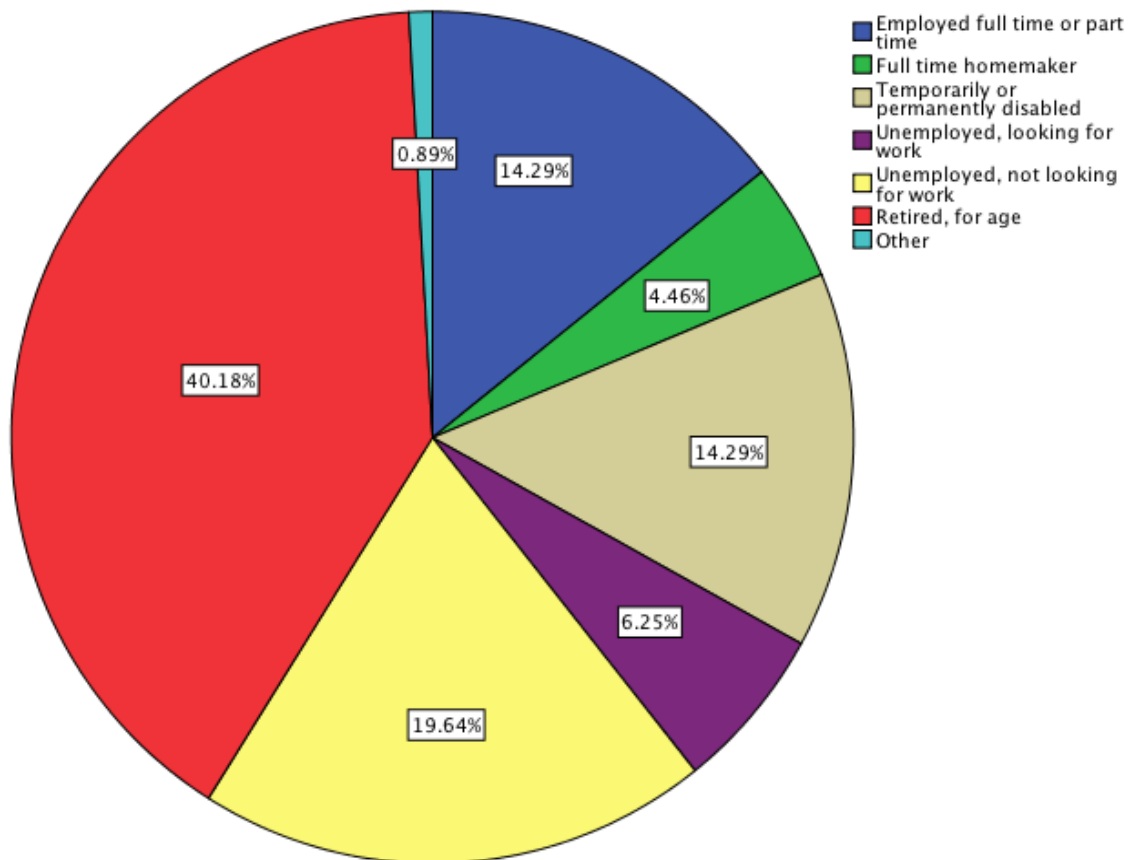
The average age of participants is approximately 50 years old—the *mean* age is 48.6 years ($n = 115$), but the standard deviation is quite high (29.3) which indicates substantial variation. This is not surprising, given that Casa Colina Hospital serves a substantial number of persons in their early or late years, and fewer persons in their 20's and 30's. Thus, the *median* (56.5 years, the age at which the half of the participants are older and half are younger) and the *range* (newborn – 103 years) might provide a more meaningful description of participants. Even with this additional information, this is still an incomplete picture of the age demographics. (This picture, which includes breaking the distribution into groups, will be discussed further in the “Additional Findings and Investigation” section.) Almost half (47.4%, $n = 116$) of the participants are married, while almost a third (30.2%) have never been married. A handful are divorced (6%), separated (3.4%), or in a committed relationship (4.3%), and 8.6% are widowed.

Figure 2. Age of Participants



Almost two thirds (63.2%, $n = 116$) have at least an associate's degree or trade certification. More specifically, participants with bachelor's degrees or master's or professional degrees represent 13.8% each and the associate's degree or trade certificate was the highest level of education for 17.2% of participants. Forty percent (40.2%) of participants who reported their work status are retired, 14.3% are temporarily or permanently disabled, and 25.9% are unemployed (19.6% not looking for work, 6.3% looking for work). The remaining respondents work full or part time (14.3%) or are full time homemakers (4.5%). Figure 3 provides a visual representation of participants' employment status.

Figure 3. Participants' Employment Status



Survey

Degree of Concern Items

The survey begins by asking participants how concerned they are (3 = “Very Concerned”, 2 = “Somewhat Concerned”, 1 = “Not at All Concerned” and 4 = “Not Applicable”) about sixteen issues. “Very Concerned” (3) was the most frequently occurring response for all but four of these issues: “Having a Place to be Social”, “Weekend/Evening Rehabilitation Services Being Offered”, “Being Able to Work Full/Part Time”, and “Having Equipment”. “Having Nurturing Caring Relationships with Family” and “Achieving/Maintaining Independence” received the greatest number of “Very Concerned” responses, with 71 and 73 ($n = 128$, or 55% and 57%) such responses, respectively. In contrast, “Weekend/Evening Rehabilitation Services Being Offered” received the highest number (58, or 45.3%) of “Not at All Concerned” responses by far, with the next highest receiving 45, 43, and 42 (“Having Equipment”, “Transportation to Get Outside Neighborhood”, and “Being Able to Work Full/Part Time”, respectively).

On a compact scale such as the one used for this survey (3 points), comparing average ratings has limited interpretability, and is not at all interpretable with the “Not Applicable” response included on the scale. Thus Table 3 displays the mean (with these responses removed) *and mode* for each of the sixteen issues presented to participants. “Achieving/Maintaining Independence” again tops the list (mean = 2.44, std = .84, $n = 92$). “Having Nurturing and Caring Relationships with Family” has the next highest mean (though much lower and just ahead of three other issues).

Table 3. Concerns for Health and Well-Being (1 = Not at all, 3 = Very)

	N	Mode	Mean	Std. Dev.
Achieving/Maintaining Independence	128	3 (73)	2.44	0.902
Having Nurturing/Caring Relationships with Family	128	3 (71)	2.31	0.82
Being Able to Receive Basic Healthcare Services	128	3 (64)	2.30	0.915

Being Able to Get Rehabilitation Services When Needed	128	3 (66)	2.28	0.821
Having Nurturing/Caring Relationships with Friends	128	3 (62)	2.27	0.882
Health Getting Worse	128	3 (57)	2.27	0.84
Being Physically Able to Get Around Neighborhood	128	3 (62)	2.25	0.765
Living in a Safe, Clean Home	128	3 (69)	2.22	0.84
Finding Rehabilitation Services Near Home	128	3 (48)	2.14	0.853
Finding Medical Care Services Near Home	127	3 (52)	2.14	0.883
Having Transportation to Get Outside Neighborhood	128	3 (51)	2.07	0.87
Having a Place to be Physically Active	128	3 (48)	2.06	0.87
Having a Place to be Social	128	2 (42)	1.98	0.765
Being Able to Work Full/Part Time, Paid/Unpaid	128	1 (42)	1.90	0.821
Having Equipment (e.g., wheelchair, cane, shower chair)	128	1 (45)	1.85	0.853
Weekend/Evening Rehabilitation Services	128	1 (58)	1.75	0.915

Needs and Their Importance Items

Participants reported how much importance they attributed to several “needs” identified in the survey. Out of seventeen such needs, “3” (“Very Important”, on a scale of 1- 3, on which 1 = “Not Important”, 2 = “Somewhat Important” and 4 = “Not Applicable”) was the most frequently occurring rating for all issues, except three: “Being Able to Work Full/Part Time” (4 and 1 were the most frequent), “Weekend/Evening Rehabilitation Services Being Offered” (2 and 1 were the most frequent), and “Counseling Services” (2, or “Somewhat Important”).

Participants recorded the highest number of “Very Important” ratings for “Adequate Health Insurance” (106, or 85.5%), “Access to Healthcare Services” (94, 75.8%), and “Living Independently” (81, 65.3%). Three other issues, “Adequate Transportation” (74, 59.7%), “Access to Physical Fitness Activities” (72, 58.1%), and “Socializing with Others” (70, 56.5%) received 70 or more “Very Important” ratings. “Weekend/Evening Rehabilitation Services Being Offered” received the highest number of “Not Important” ratings (41, 33.1%), followed by “Part/Full Time Work” (36, 29%), and “Counseling Services” (33, 26.8%). Table 4 displays the

mean (with “Not Applicable” responses removed) and mode for each issue. “Adequate Health Insurance” (2.80, std. = .559), “Access to Healthcare Services” (2.72, std. = .582), and “Living Independently” (2.64, std. = .644) have the highest mean ratings of importance. Like the items about participants concerns, these items of importance also employed a compact scale, so the same caveat stated for means reported in Table 3 applies here.

Table 4. Importance of Needs (1 = Not, 3 = Very)

	N	Mode	Mean	Std. Dev.
Adequate Health Insurance	124	3 (106)	2.80	.559
Access to Healthcare Services	124	3 (94)	2.72	.582
Living Independently	124	3 (81)	2.64	.644
Adequate Transportation	124	3 (74)	2.57	.654
Socializing with Others	124	4 (70)	2.55	.563
Access to Physical Fitness Activities	124	3 (72)	2.53	.650
Being Physically Able to Get Around Neighborhood	124	3 (68)	2.46	.730
Being Physically Able to Get Outside Neighborhood	124	3 (62)	2.43	.693
Housing Adapted for Persons with Disabilities	124	3 (56)	2.39	.747
Having a Place to be Socially Active	124	3 (58)	2.38	.662
Recreation Opportunities	124	3 (60)	2.36	.719
Educational Programs	124	3 (65)	2.33	.811
Caregiver Services	124	3 (53)	2.27	.786
Having Equipment (e.g., wheelchair, shower chair)	123	3 (48)	2.27	.836
Counseling Services	123	2 (39)	2.05	.806
Weekend/Evening Rehabilitation Services	124	2,3 (41)	1.94	.805
Part/Full time Work	124	4 (37)	1.94	.881

Quality of Life

Participants were also asked five questions about their quality of life. The first three questions asked participants to rate their health, overall quality of life, and social activities and relationships on a scale in which 1 = Excellent, 2 = Very Good, 3 = Good, 4 = Fair, and 5 = Poor. Participants most commonly reported their Health as “Fair” (27.6%) and their Overall Quality of Life and their Social Activities and Relationships as “Good” (both 30.9%). Table 5

displays the mean and mode for each of these three items.

Table 5: Quality of Life (1 = Excellent, 5 = Poor)

	N	Mode	Mean	Std. Dev.
Health	123	4 (34)	3.02	1.22
Social Activities and Relationships	123	3 (38)	2.77	1.23
Overall Quality of Life	123	3 (38)	2.74	1.22

Almost half of participants (40.20%, $n = 122$) reported that they are completely able to carry out everyday activities and roughly 60% reported being at least mostly able to carry out daily activities independently, while 9% reported that they cannot do so at all. On a scale ranging between 1 (Completely) and 5 (Not at All), the mean of responses is 2.32 (std. = 1.36, $n = 122$, mode = 1). Finally, 33.6% ($n = 122$) of respondents reported that they “Sometimes” experience emotional problems such as feeling anxious, depressed, or irritable. Only 6.6% participants reported “Always” experiencing such feelings. One online participant, a person whose doctor recently recommended Casa Colina Hospital, reported feeling irritable all the time because of constant pain. On a scale ranging between 1 (Never) and 5 (Always), the mean of the responses for frequency of emotional problems is 2.79 (std. = 1.16, $n = 122$, mode = 3).

Focus Group

The evaluators conducted a focus group with industry professionals working in sectors specifically related to caring for persons with disabilities or at risk for disability. Four recurring themes regarding needs and appropriate responses by Casa Colina Hospital emerged from the focus group: “Consideration of the Family of Persons with Disabilities”, “Responsible and Creative Responses to Fiscal Challenges”, “Support for Independent Quality of Life (including Transportation, Access to Social/Recreational Activities, Productivity, etc.)”, and “Practical

Information & Resources”.

Participants identified financial challenges and interference with productivity and social and healthy recreational activities as the top frustrations and challenges facing persons with disabilities. One participant noted that it’s important for persons to feel a sense of contribution and productivity. Building on that, another participant stated that there are not enough opportunities for recreation and social activity, adding, “There just aren’t enough *healthy* activities that these persons *can* participate in.” The group agreed that these challenges result, in part, from financial challenges, but that financial difficulties also impact transportation, desirable housing, and the availability of additional therapy. One group member noted, “with the current financial burden that everybody’s under...these families [of persons with disabilities] are being hit with cuts multiple times through the multiple systems they access.”

While participants noted that in recent years more work has been done to make parks, trails, communities, and public transportation more accessible, they also worried that such efforts may not continue in this climate of budget cuts. Another major concern about attempts to address challenges for persons with disabilities is the lack of sustainability. Despite these challenges, participants identified gathering and providing information about resources and efforts to make practices more “family-centered” as low cost projects that can address some of the challenges discussed.

A few issues arose that coalesce around “quality of care”, which might be thought of as a smaller, or minor, but important, theme. For example, one participant noted that persons with disabilities might need more time to express needs. That need might arise because the patient’s condition impacts ability to communicate or because the care provider spends too much time focusing on the disability, overlooking the fact that the patient has issues other than the

disability. It was also noted that appointment times, especially particularly early times, can be difficult for persons with disabilities who also depend on public transportation. Additionally, group members mentioned difficulties with the way some care providers interact with persons with disabilities. Some care providers have a tendency to speak to the person accompanying the person with a disability rather than the person herself, sometimes in language that the patient cannot understand. Participants cautioned however, that care providers can take things too far in the other direction and appear to be talking down to the patient or treating the patient as a child.

The group recognized that solutions to the problems just described essentially require more time: time for longer appointments, time to identify appointment schedules that will work for the particular client, time to devote to interacting with client's caregiver(s). One solution proposed by participants was to employ or expand the team care approach, tasking the highest paid, highest credentialed staff only with the things that actually require their level of training. Meanwhile, qualified staff without an MD, RN, or PT can be assigned to caring for patient care tasks that do not require such credentials.

“[T]hat’s what I’ve found that people get so much value. Sitting in the waiting room talking to another parent or another person that has the same thing going and that’s where you get a lot of the information, resources, and knowledge.”

Some suggestions for how Casa Colina Hospital could address the needs of the community cut across themes. For example, discussions about wait times, giving more attention to families or caregivers of the persons with disabilities, fiscal challenges, providing resources, and providing activities for patients before and after appointments culminated in the suggestion to provide a space, preferably a room that could simultaneously address all of these needs. The

basic idea involves a comfortable room or space where patients and their families can wait for appointments or visit before and after appointments. “[T]hat’s what I’ve found that people get so much value. Sitting in the waiting room talking to another parent or another person that has the same thing going and that’s where you get a lot of the information, resources, and knowledge... I think that can be something that is more conducive depending on how it’s set up.”

Because “Casa Colina has such expertise, it can produce simple to understand, written materials that can tell families and care providers about...their health conditions and risks for disabilities and what *they* can do.” This was compared to “the pages on PubMed” as a way to “empower older adults, adults with disabilities, and aging adults with disabilities.”

“Casa Colina has such expertise, it can produce simple to understand written materials that can tell families and care providers about... their health conditions and risks for disabilities and what *they* can do.”

Such information, and information gathered on resources, could be made available in a “coffee room that’s open for people” that “could also have books, support group lists, and the resources that have been gathered.” Not only could such a room, dubbed a “resource room”, make the wait times comfortable and potentially productive, but would provide an ideal space for connections and information exchanges between patients and caregivers to arise naturally. Patients and their families would know that this was the place to go to find information about prevention, wellness and health maintenance, transportation assistance, assistance from community agencies, and social or recreational activities and to connect with other patients and caregivers that might also have useful information.

The group also suggested using equipment in outpatient rehabilitation services to promote exercise for people (especially older people and people with disabilities) in the

community who need monitored or adapted recreation opportunities. This was expressed as a way of using existing resources in what might be a low cost way to provide some of the healthy recreation activities that are so needed in the community of persons with disabilities.

Additional Investigation and Findings

The preceding sections on the community questionnaire and the focus group present the general findings for the entire sample. There is another way of viewing and describing the data, however, which may provide a more meaningful picture of community needs. Table 6 displays the mean and mode for two of the items presented in Table 4. Based on the measures of central tendency provided, responses to these two items appear to be very similar. The mode for both items is 3 (“Very Important”) with close to the same number of responses of that kind. The means are also very close—only .001 apart. When one views the actual frequencies of the individual response categories, however, it is clear that the responses for these items are not quite as similar as they initially appear. The “socially active” item is essentially bimodal, with 109 responses fairly evenly split between “Somewhat Important” and “Very Important.” While the adaptive housing item has roughly as many “Very Important” responses (56) as the “socially active” item, it has substantially fewer “Somewhat Important” responses (30). Twenty-two participants (18%) responded that the item for adapted housing was not applicable to them. This increased the ratio of “Very Important” to other responses, so that the two items yield the same mean for differing reasons.

Table 6. Mean and Mode for Two “Needs” Items from Questionnaire

How important are these needs to you?	N	Mode	Mean	Std. Dev.
Housing Adapted for Persons with Disabilities	124	3 (56)	2.39	.747
Having a Place to be Socially Active	124	3 (58)	2.38	.662

Table 7. Frequencies for Ratings of Importance of a Selection of Needs

How important are these needs to you?	N	1 Not	2 Somewhat	3 Very	N/A
Housing Adapted for Persons with Disabilities	124	16	30	56	22
Having a Place to be Socially Active	124	12	51	58	3

It is the bimodal nature of the “Socially Active” item that is most interesting. In fact, there are several bimodal (and even some tri-modal) items in the “Concern,” “Need,” and “Quality of Life” sections of the questionnaire. Tables 8 and 9 display the frequencies for these items. A possible interpretation of these findings is that the sample represents multiple distinct populations with differing opinions about these items.

Table 8. Frequencies for Multi-modal “Concern” and “Needs” Items

	N	1 Not	2 Somewhat	3 Very	N/A
<u>Concern</u>					
Having a Place to be Social	128	41	42	39	6
Having a Place to be Physically Active	128	41	31	48	8
Finding Rehabilitation Services Near Home	128	31	42	48	7
<u>Needs</u>					
Part/Full time Work	124	36	20	31	37
Having a Place to be Socially Active	124	12	51	58	3
Need: Weekend/Evening Rehabilitation Services	124	41	41	34	8
Need: Counseling Services	123	33	39	38	13

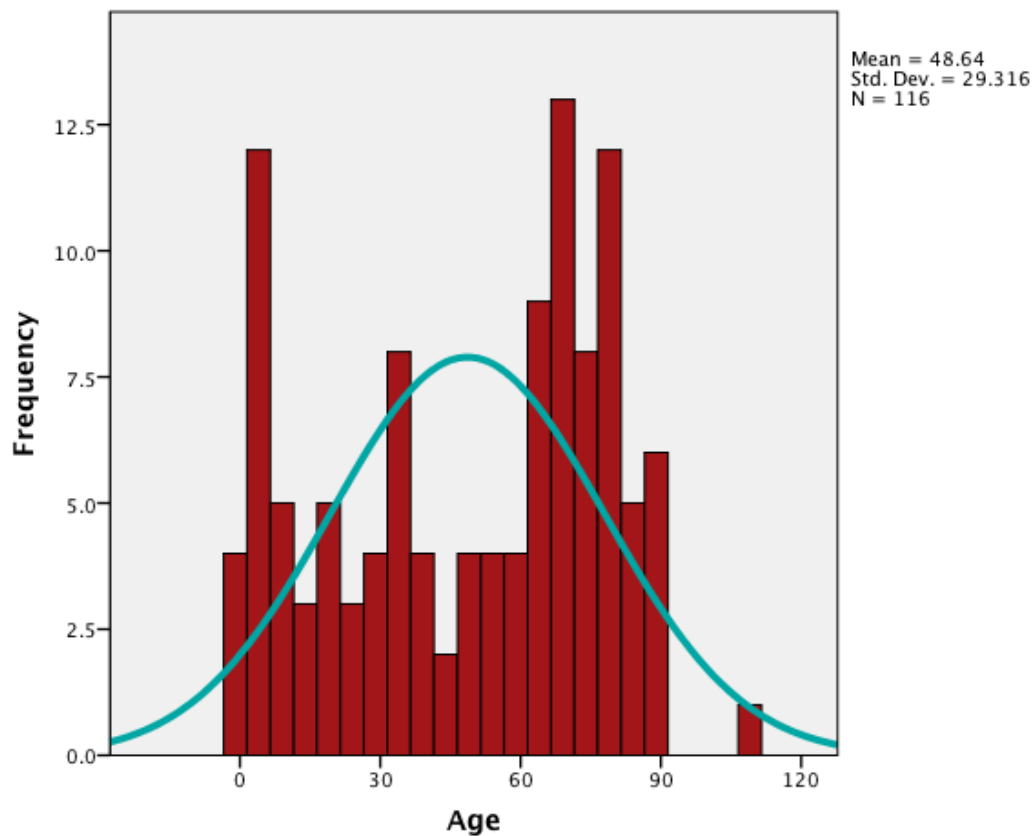
Table 9. Frequencies for Multi-modal “Quality of Life” Items

Questionnaire Item	N	Excellent	Very Good	Good	Fair	Poor
Health	123	128	41	42	39	6
Social Activities and Relationships	123	128	41	31	48	8

A closer look at the descriptive data for the age of participants provides support for the second interpretation. Recall that the mean age for the sample is 48.64. The distribution of a typical sample from a single population will follow a normal curve, such that the individual

measurement values tend to cluster around the mean and gradually thin out toward the extreme scores at either end of the range. Hence, assuming a normal curve, one would expect that most of the participants in our sample are between 40 and 60, or perhaps within an even narrower range, between 45 and 55, with the most frequently occurring values occurring at approximately 48 – 50 years of age. In fact, this range contains the lowest density of high frequency age values. A visual representation of the distribution is presented in Figure 4. From a careful examination of that graph, one can see what appear to be three distinct normal distributions.

Figure 4. Age of Participants



Accordingly, the evaluators calculated a new age variable, “Age Groups,” containing three groups: “Youth” (0 – 15), “Adults” (17 – 50), and “Seniors” (51 – 108). As one would

expect, this yields three distributions with approximately normal curves, as shown in Figures 5–7.

Figure 5. “Youth”

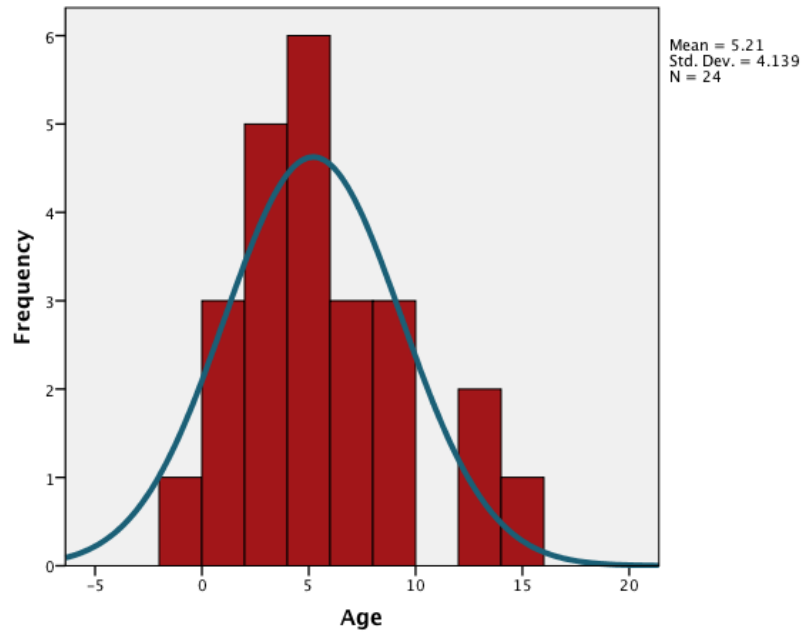


Figure 6. “Adults”

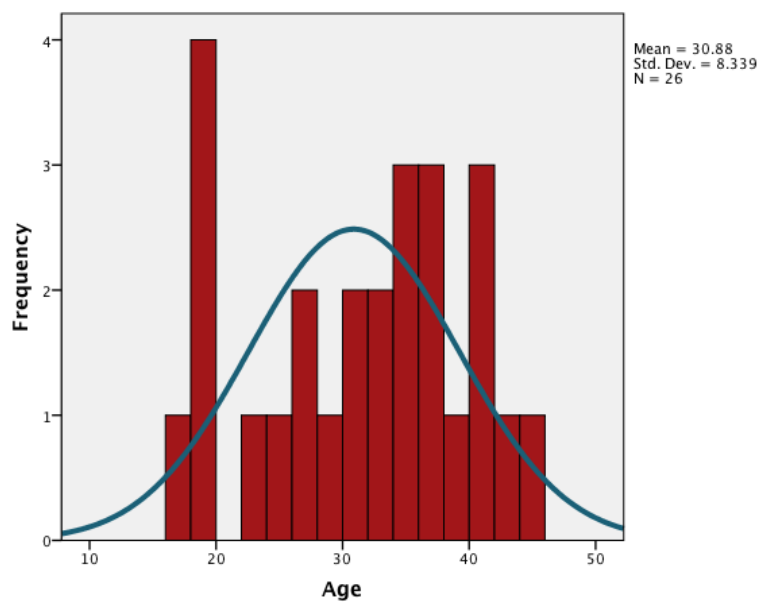
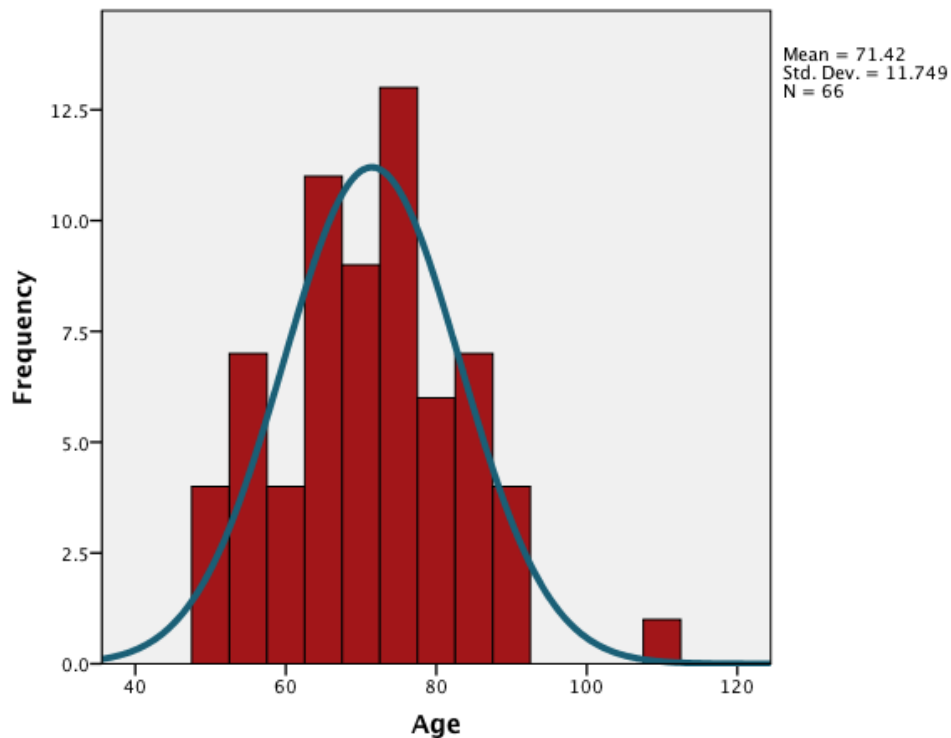


Figure 7. “Seniors”



Preliminary analysis treating the sample as three groups and comparing group responses for the items in Tables 8 and 9 reveals that the differences between the groups' responses are statistically significant for all but two of these items. Additionally, as suspected, some of the bimodal qualities of the items in Tables 8 and 9 are explained by distinct modes between groups. Table 10 juxtaposes the frequencies of responses by age group with those of the entire sample for three of the bimodal items in Tables 8 and 9. Table 11 displays the significance values for all of the items in Tables 8 and 9.

Table 10. Full Sample & Distinct Age Group Responses for Three Bimodal Items

	1 Not	2 Somewhat	3 Very	4 N/A
Part/Full time Work				
Full Sample	36	20	31	37
Youth	0	2	6	16
Adults	2	6	16	2
Seniors	32	10	8	16
Having a Place to be Socially Active				
Full Sample	12	51	58	3
Youth	0	8	15	1
Adults	0	8	18	0
Seniors	11	32	22	1
Counseling Services				
Full Sample	33	39	38	13
Youth	3	6	8	7
Adults	4	6	16	0
Seniors	24	25	11	5

Table 11. Differences Among Age Groups for Bimodal Items

	Value	df	Significance
<u>Concern</u>			
Having a Place to be Social	9.57	4	0.048
Having a Place to be Physically Active	13.24	4	0.010
Finding Rehabilitation Services Near Home	7.59	4	0.108
<u>Needs</u>			
Part/Full time Work	54.99	6	0.000
Having a Place to be Socially Active	18.04	6	0.006
Weekend/Evening Rehabilitation Services	13.83	6	0.032
Counseling Services	30.88	6	0.000
<u>Quality of Life</u>			
Health	19.99	8	0.010
Social Activities and Relationships	4.65	8	0.794

Table 12. Frequencies for Multi-modal “Quality of Life” Items

Questionnaire Item	N	Excellent	Very Good	Good	Fair	Poor
Health	123	128	41	42	39	6
Social Activities and Relationships	123	128	41	31	48	8

Conclusions and Recommendations

Conclusions

As is clear in Tables 3 and 4, participants rate all of the needs and concerns presented in the survey as of great concern or need. “Very...” is the most frequent response for 29 of 33 such items. Some issues stand out as being of greater importance or concern, and in some cases, there is overlap between the items of great importance and the items of great concern. For example, receiving basic health care services was in the top three for both Concerns and Needs items. Concern about “Health Getting Worse” ranks highly, precisely as one would expect, given this importance and concern attributed to receiving basic healthcare services. Independent living also ranks high for both sets of items.

In contrast, although “Being Able to Receive Rehabilitation Services When Needed” ranks high among the Concern items (a similar item is not included in the Need survey items), “Weekend/Evening Rehabilitation Services” in the bottom two among both the Need and the Concern Items. This would seem to suggest that having such services available in the evenings or on the weekends is not a priority for participants. “Being Able to Work Full/Part Time” also ranks near the bottom for both sets of items, again suggesting lower priority for this issue. The same is true, though to a lesser degree, of “Having Equipment (e.g., wheelchair, cane, shower chair)”.

Of greater interest is how some questionnaire responses match with opinions and suggestions recorded in the focus group. Questionnaire participants, who are in the population of interest, consistently rated independent living and receiving basic healthcare services as of great concern and importance. Focus group participants devoted substantial attention to things they thought Casa Colina Hospital could do to support independent living and improve healthcare appointment services despite the financial challenges most institutions are facing today. The

most productive suggestion to arise along these lines was the establishing of a “resource room” where patients and their families could browse information about health issues and available resources, network with other patients and families, and perhaps even enjoy coffee and relax. If Casa Colina has an existing space that could be used or repurposed to this effect, this appears to be a low cost way to meet at least some of the needs and concerns of the community it serves.

The other two major suggestions to emerge from the focus group also seem like reasonable recommendations, although they might both involve a greater initial investment of time and fiscal resources. While having a place to be physically active or engage in physical fitness activities was not *ranked* high, these still received more “Very Important” or “Very Concerned” responses than many other items. Thus, if it would not be of substantial cost (either in terms of personnel or liability) to Casa Colina, adopting the focus group’s other suggestion, opening access to the equipment used for outpatient rehabilitation could effectively address another important need in the community. And finally, the “team care” approach suggested by focus group participants, if not already in practice, may require substantial procedural training in the beginning, but long term, in theory, it would save money or allow that money to be spent allowing doctors and professionals to spend more time with patients.

Trends

“Being Able to Receive Rehabilitation Services When Needed” and “Health Getting Worse” ranked high not only among the concerns in this 2012 needs assessment, but also in the assessments for 2003 and 2009. Likewise, “Having Equipment” and “Being Able to Work Full/Part Time” has ranked low for all three needs assessments. On the other hand, concerns about access to transportation, social activities, and physical activities have fluctuated between assessments. In terms of needs considered important, “Counseling Services” ranked among the

least important needs in all three studies, and “Being Able to Work Full/Part Time” ranked among the least important for the last two studies (2009 and 2012). “Adequate Health Insurance” was the highest ranked need and “Access to Health Care Facilities” the second highest, in the community needs assessment for 2003, 2009, and 2012. Health insurance was also of great concern among focus group participants, who worried that changes resulting from healthcare reforms might threaten some of the services currently received by persons with disabilities. Were these fears to be realized, the gathering and providing of information about free or low-cost resources, as suggested above, would likely be all the more valuable to persons in Casa Colina Hospital’s community who have disabilities or are at risk for disability.

Some of the enduring needs or concerns among persons with disabilities may be out of Casa Colina Hospital’s scope. For example, it seems unlikely that Casa Colina can do much, at least directly, to ensure or increase the availability of adequate health insurance. Likewise, Casa Colina Hospital is likely not in a position to increase access to other healthcare facilities. Increasing access to its own facilities is an option only if the hospital is in a position to direct funds to support such access. Casa Colina can address one of the enduring concerns: concern about health getting worse. The resource room already mentioned can provide information focusing on prevention and health maintenance, and because of its expertise noted by a focus group participant, Casa Colina hospital can provide this information tailored to specific disabilities and conditions. The information about free or low cost services might also help to fill some of the gaps created by inadequate health insurance, thus indirectly meeting another enduring need.

Recommendations

Repurposing space to provide a resource room, while not necessarily directly solving

patient problems or meeting their healthcare needs, does help patients find help and ways to meet these needs. In some cases, prevention and maintenance information may be precisely what persons served by Casa Colina Hospital need. This appears to be a low cost way of addressing at least some of the community needs.

Having access to rehabilitation services is a concern and an important need in the community, but participants indicate that having evening and weekend rehabilitation services is not as important. Perhaps providing evening and weekend services some how does not meet the reported need. It is recommended that Casa Colina consider administering a very brief, simple survey to patients and other community members, perhaps as patients check in and through the website and mailers, to see what access to these services persons with disabilities in this community need.

Finally, the other two suggestions that emerged are that Casa Colina (1) make outpatient rehabilitation equipment open to community members with disabilities or at risk for disability and (2) implement or expand the “team care” approach. Casa Colina has a Fitness Program that gives community members the opportunity to use the outpatient services gym for self-directed maintenance regimens at a very small monthly fee. Also for a small fee, the outpatient therapy pools are available to members of the community for an aquatic exercise program that occurs three sessions a day, five days a week. This program hosts about 7,000 visits a year. Additionally, Casa Colina pioneered the treatment team model in the 1980’s and has used it system-wide since that time.

APPENDIX A

California Department of Public Health, Epidemiology and Prevention for Injury Control, Office on Disability and Health ODH TAKE ACTION Advisory Committee 2007-2012

Name	Position	Organization
Harriet Aronow, Ph.D.	Research Scientist in Health Services Delivery, Department of Nursing	Cedars-Sinai Medical Center
Kim Cantrell	Director of Programs	California Foundation for Independent Living
Anne Cohen	Disability Health Access	
Leah Fitzgerald, Ph.D., C-FNP	Assistant Professor	UCLA School of Nursing
Joan Earle Hahn, Ph.D., APRN, GCNS-BC, CNP-BC, CDDN	Associate Professor, Gerontological Nurse Practitioner	University of New Hampshire, College of Health and Human Services
Paul Glassman, DDS, MA, MBA	Professor of dental practice and Director of Community Oral Health, member of the federal Agency for Healthcare Research and Quality's expert panel on assessing healthcare quality measures.	Advanced General Dentistry Residency, University of the Pacific Arthur A. Dugoni School of Dentistry
Maureen Harrington	Program Manager	Pacific Center for Special Care, University of the Pacific Arthur A. Dugoni School of Dentistry
Brooke Holister	Assistant Professor	Department of Social and Behavioral Sciences, Institute for Health & Aging, University of California San Francisco
Christina Hooke	License Counsel, Access Dental Plan	Department of Managed Health Care
Ben Jauregui,	Disability Program Manager	Inland Empire Health Plan
June Isaacson Kailes	Disability Policy Consultant	Center for Disabilities Issues and the Health Professions, Western University of Health Sciences
Kathony Jerauld	Program Manager	Center for Gerontology

Angela Kaufman	ADA Coordinator	Department on Disability, City of Los Angeles
Lisa Kodmur	Program Director	Services for Seniors and People with Disabilities, L.A. Care Health Plan
Lewis Kraus	Deputy Director	Center on Disability at the Public Health Institute
Florita Maiki-Toveg	Clinical Director for Women's Health Program and Disability Center	Alta Bates Summit Medical Center
Tami MacAller	Senior Area Health Promotion Specialist in the Northern Central Valley Area	California Diabetes Program
Christina E. Miller	Associate Professor, Director, Community Program; Co-Director, Pacific Center for Special Care	University of the Pacific, Arthur A. Dugoni School of Dentistry
Renate Henry Olaisen	Director of Aquatic Services	Abilities United
Elizabeth Pazdral	Executive Director	California State Independent Living Council
Debbie Sarmento	Representative	Interagency Coordinating Council on Early Intervention
Janet Tedesco, MA	Chronic Disease Self Management Program, Evidence Based Healthcare Practices Initiative	California Department of Aging
David Wilder	Chairman	California State Independent Living Council

APPENDIX B

Report Personnel

Tarek Azzam, Ph.D., Institute for Organizational and Program Evaluation Research
Claremont Graduate University, Faculty Supervisor for James Griffith

Dr. Tarek Azzam's work focuses on developing methods that enhance the likelihood of evaluation use. He conducts this work by studying the contextual factors that influence the evaluation process and by creating interactive systems that reduce information complexity. The interactive systems are capable of representing various data forms (quantitative and qualitative) and allow users to view data and information at a broad conceptual level and delve to deeper levels of analysis when they choose to do so. Dr. Azzam was involved in the design and creation of these systems for a number of organizations such as the Rockefeller Foundation and First 5 LA.

Dr. Azzam is also the recipient of multiple Department of Education evaluation grants that test the effectiveness of higher education academic support programs. As part of the UC Riverside evaluation grant, Dr. Azzam designed and implemented a fully randomized control trial to test the impact of a student mentoring program on the academic achievement of students. This study is one of the few randomized control trials implemented at UCR, and the findings from this study will influence the shape of similar programs across the UC system. In addition, Dr. Azzam has conducted qualitative case studies that examined the impact of Department of Child and Family Services' (DCFS) policies on three urban communities, and is currently involved in other evaluations involving the juvenile justice system, and various urban school districts.

Dr. Azzam was the cofounder of the Research on Evaluation Topical Interest Group for the [American Evaluation Association](#) (AEA), and has helped to generate interest in the topic by promoting papers and research projects that discuss the methods and research questions that concern practicing evaluators. He is also the former chair of AEA's awards committee, and is involved in the evaluation and selection of awardees. Dr. Azzam received his doctorate in Social Research Methodology from the University of California, Los Angeles.

James Griffith, M.A., ABD, Institute for Organizational and Program Evaluation Research
Claremont Graduate University

James Griffith is a graduate student at Claremont Graduate University and was responsible for the organization, execution and analysis of this report, working under the guidance of Dr. Azzam.



**Casa Colina Hospital for Rehabilitative Medicine
2012 Community Needs Assessment
Group Difference Analysis Supplement**

Prepared for
Casa Colina Hospital for Rehabilitative Medicine
Pomona, California

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This is a supplement to the 2012 Casa Colina Hospital Community Needs Assessment final report. That document reported the findings from the questionnaires and the focus group as applicable to the entire sampled population Casa Colina Hospital serves. In addition, it identified the fact that the assessment population was actually composed of three distinct populations, or groups, and drew attention to some of the differing responses, indicating differing needs or interests, between the groups. The section reporting on these differing groups focused on the indicators that signaled the possibility of different populations, multi-modality of age distribution and of responses to several of the questionnaire items, and on the findings directly related to those indicators. Although examining differing needs for distinct groups was not originally a goal of the needs assessment, it was deemed interesting enough for closer examination and for possible strategic inclusion in the next community needs assessment. The purpose of this supplement is to expand upon those findings and examine the differences between groups for the full range of questions on the questionnaire. In the interests of allowing the supplement to serve as a free-standing document, the next few paragraphs combine elements from the final report's introduction and from a later section entitled "Additional Investigation and Findings" to fill out the introduction for this supplement. Additionally, *all* questionnaire items, including those already discussed, albeit briefly, in the final report, are included in this supplemental report.

While the results of this analysis of group differences immediately impact only a couple of items, it nonetheless highlights important and statistically significant differences in needs and preferences between three age groups served by Casa Colina Hospital for Rehabilitation. This suggests that to accurately assess the needs of the community of persons with disabilities or at risk for disability, future assessments should include a consideration of these group differences. The analysis concludes with a brief discussion of how the trends reported in the 2003, 2006, and 2012 needs assessments compare to responses across groups.

Introduction and General Results

Casa Colina Hospital for Rehabilitative Medicine in Pomona is a 68-bed acute licensed specialty hospital with additional services that include an outpatient rehabilitation service, specialist physician clinics, outpatient children's rehabilitation services, and a satellite outpatient rehabilitation unit in Azusa. As an institution focused on rehabilitative medicine, it considers the community it serves to be persons with disabilities or who are at risk of disabilities, and who can benefit from rehabilitation. This is the sense in which "community" is used throughout this supplemental report.

Casa Colina Hospital commissioned the evaluation group from Claremont Graduate University's Institute for Organizational and Program Evaluation Research to conduct a community needs assessment for 2012. To carry out this study, the evaluators administered a questionnaire that was delivered to community members either as a scripted phone interview or as an online survey, and they conducted a focus group with industry professionals and experts from an advisory group to the California Office of Public Health's Office on Disability and Health (ODH TAKE ACTION Advisory Committee). The findings were presented in March 2012. This analysis of differences between three groups within the community will focus on the questionnaire administered to the community and not on the focus group conducted with industry professionals.

The foci of the questionnaire were three sets of questions (1) regarding issues about which community members might be concerned, (2) asking about the importance placed by community members on particular needs, and (3) asking for a rating of the community members' quality of life on five dimensions. Participants were asked how concerned they are about a number of issues (3 = "Very Concerned", 2 = "Somewhat Concerned", 1 = "Not at All Concerned" and 4 = "Not Applicable"). "Health Getting Worse" (N = 128, 54% Very concerned, mean = 2.44, std. dev. = 0.902), "Being Able to Receive Rehabilitation Services When Needed" (N = 128, 33% Very concerned, mean = 2.31, std. dev. = 0.82), and "Receiving Basic Healthcare Services" (N = 128, 34% Very concerned, mean = 2.30, std. dev. = 0.915) emerged as the issues about which respondents

reported being most concerned. In fact, two of these items, “Health Getting Worse” and “Being Able to Receive Rehabilitation Services When Needed”, have also stood out as concerning community members most in the needs assessments for 2003 and 2009. “Being Able to Work Full/Part Time”, “Counseling Services”, and “Having Equipment” have ranked low among the needs and concerns in the survey, and have done so since the time of the study conducted in 2003.

Participants were next asked how much importance they attributed to several “needs” identified in the survey (3 = “Very Important”, 2 = “Somewhat Important”, 1 = “Not Important” and 4 = “Not Applicable”). “Very Important” was the most frequently occurring rating for fourteen out of the seventeen items. Participants recorded the highest number of “Very Important” ratings for “Adequate Health Insurance” (103, or 85.5%), “Access to Healthcare Services” (94, 45.8%), and “Living Independently” (81, 35.3%). Finally, participants were asked about five quality of life issues (including one overall “Quality of Life” item). The first three questions asked participants to rate their health, overall quality of life, and social activities and relationships on a scale in which 1 = Excellent, 2 = Very Good, 3 = Good, 4 = Fair, and 5 = Poor. Participants most commonly reported their Health as “Fair” (24.3%), and their Overall Quality of Life and their Social Activities and Relationships as “Good” (both 30.9%). The other two questions asked about participants’ ability to carry out everyday activities and frequency with which they face emotional problems. Almost half of participants (40.20%, $n = 122$) reported that they are completely able to carry out everyday activities and roughly 30% reported being at least mostly able to carry out daily activities independently. On a scale ranging between 1 (Never) and 5 (Always), the mean of the responses for frequency of emotional problems is 2.49 (std. = 1.13, $n = 122$, 3/“Sometimes” = 41%). For more detail, and a more thorough discussion, regarding the findings for the general community served by Casa Colina Hospital, see the final report, and Tables 3 – 5 in particular.

Different Groups

Two interesting features, one of the findings for all three sets of items and one concerning an aspect of the demographic data, motivated the evaluators to review the data with a different approach. (For a full treatment of the demographic data collected through the questionnaire, see “Participants” in the final report.) The interesting feature in the findings for all three sets of items is the presence of *several* multi-modal items. Unidentified and unconsidered bimodal distributions can present a skewed impression of the data. Table 13 displays the mean and **mode** for two items regarding the importance of needs.

Table 13. Mean and Mode for Two Needs Items from Questionnaire

How important are these needs to you?	N	Mode	Mean	Std. Dev.
Housing Adapted for Persons with Disabilities	124	3 (56)	2.39	.444
Having a Place to be Socially Active	124	3 (58)	2.38	.332

Based on the measures of central tendency provided, responses to these two items appear to be very similar. The mode for both items is 3 (“Very Important”) with close to the same number of responses of that kind. The means are also very close—only .001 apart. When one views the actual frequencies (Table 14) of the individual response categories however, it is clear that the responses for these items are not quite as similar as they initially appear.

Table 14. Frequencies for Ratings of Importance of a Selection of Needs

How important are these needs to you?	N	1 Not	2 Somewhat	3 Very	N/A
Housing Adapted for Persons with Disabilities	124	16	30	56	22
Having a Place to be Socially Active	124	12	51	58	3

The “Socially Active” item is essentially bimodal, with 109 of 124 responses fairly evenly split between “Somewhat Important” (51) and “Very Important” (58). In contrast, although the

adaptive housing item has roughly as many “Very Important” responses as the “Socially Active” item (56 vs. 58), it has substantially fewer “Somewhat Important” responses (30 vs. 51). Twenty-two participants (18%) responded that the item for adapted housing was not applicable to them. This increased the ratio of “Very Important” to other responses, so that the two items yield the same mean for differing reasons.

It is the bimodal nature of the “Socially Active” item that is most interesting. In fact, there are several bimodal (and even some tri-modal) items in the “Concern,” “Need,” and “Quality of Life” sections of the questionnaire, but only one other item had a high frequency of “Not Applicable” responses. Tables 15 and 16 display the frequencies for all of the multi-modal items.

Table 15. Frequencies for Multimodal Concern and Needs Items

	N	1 Not	2 Somewhat	3 Very	N/A
<u>Concern</u>					
Having a Place to be Social	128	41	42	39	3
Having a Place to be Physically Active	128	41	31	48	8
Finding Rehabilitation Services Near Home	128	31	42	48	4
<u>Needs</u>					
Part/Full time Work	124	33	20	31	34
Having a Place to be Socially Active	124	12	51	58	3
Need: Weekend/Evening Rehabilitation Services	124	41	41	34	8
Need: Counseling Services	123	33	39	38	13

The occurrence of multiple modes is open to several possible interpretations. It is possible that opinions among the sampled population are simply “split” on the issue in question. Of course, it is also possible that the sampled population doesn’t really have a strong opinion about the issue—if we randomly assigned 99 ratings on a three point scale, we would expect these to be distributed roughly evenly across the three possible ratings, yielding a tri-modal (33, 33, and 33) result. Another possible interpretation of these findings is that the sample represents multiple distinct populations with

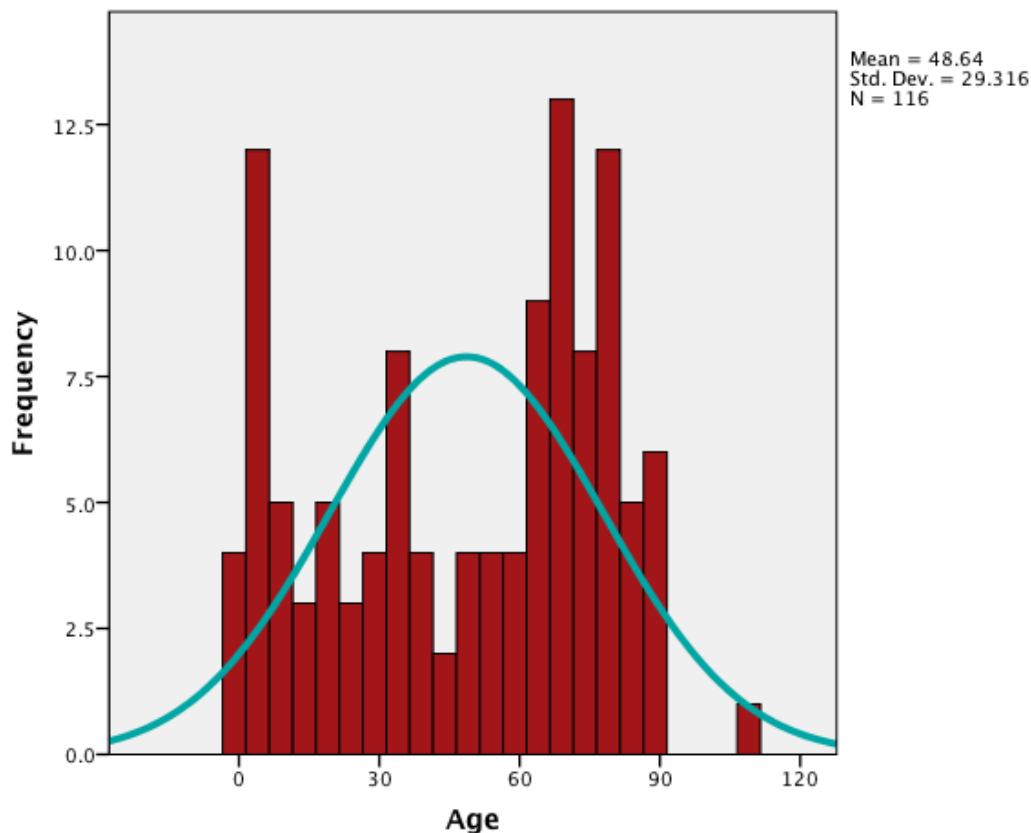
differing opinions about these items.

Table 16. Frequencies for Multimodal Quality of Life Items

Questionnaire Item	N	Excellent	Very Good	Good	Fair	Poor
Health	123	128	41	42	39	3
Social Activities and Relationships	123	128	41	31	48	8

The second interesting feature motivating a secondary analysis of the data was the age distribution in the sample. A closer look at the descriptive data for the age of participants provides support for the latter interpretation of the multi-modal data. The average age of participants is approximately 50 years old—the *mean* age is 48.3 years ($n = 115$), but the standard deviation is quite high (29.3) which indicates substantial variation. The *median* (the age at which the half of the participants are older and half are younger) is 53.5 years, and the *range* is newborn – 103 years. The distribution of a continuous variable (e.g., age, weight, temperature, score) of a typical sample from a single population will follow a normal curve (sometimes called a “bell curve”), such that the occurrence of individual measurement values tend to cluster around the mean and gradually thin out toward the extreme scores at either end of the range. Hence, assuming a normal curve, one would expect that most of the participants in our sample are between 40 and 60, or perhaps within an even narrower range, between 45 and 55, with the most frequently occurring values occurring at approximately 48 – 50 years of age. In this particular case however, this range contains the *lowest* density of high frequency age values. Not surprisingly then, the visual representation of the distribution presented in Figure 8 does not resemble a normal curve. From a careful examination of that graph, however, one can see what appear to be *three distinct* normal distributions.

Figure 8. Age of Participants



Accordingly, the evaluators calculated a new age variable, “Age Groups,” containing three groups: “Youth” (0 – 15), “Adults” (14 – 50), and “Seniors” (51 – 108). As one would expect, this yields three distributions with approximately normal curves, as shown in Figures 9 – 11. Preliminary analysis treating the sample as three groups and comparing group responses for the items in Tables 15 and 16 revealed that the differences between the groups’ responses are statistically significant for all but two of these items.

Figure 9. "Youth"

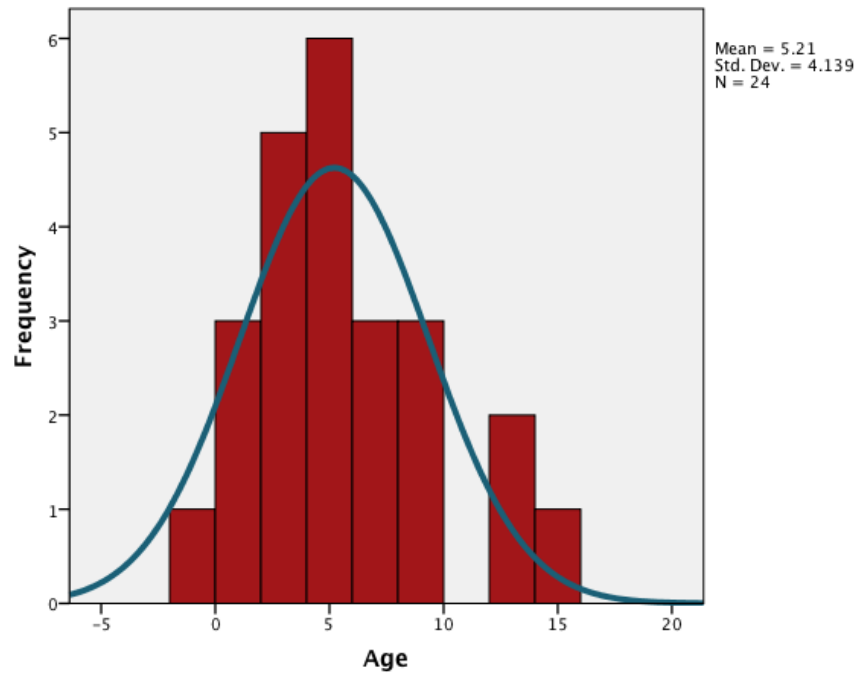


Figure 10. "Adults"

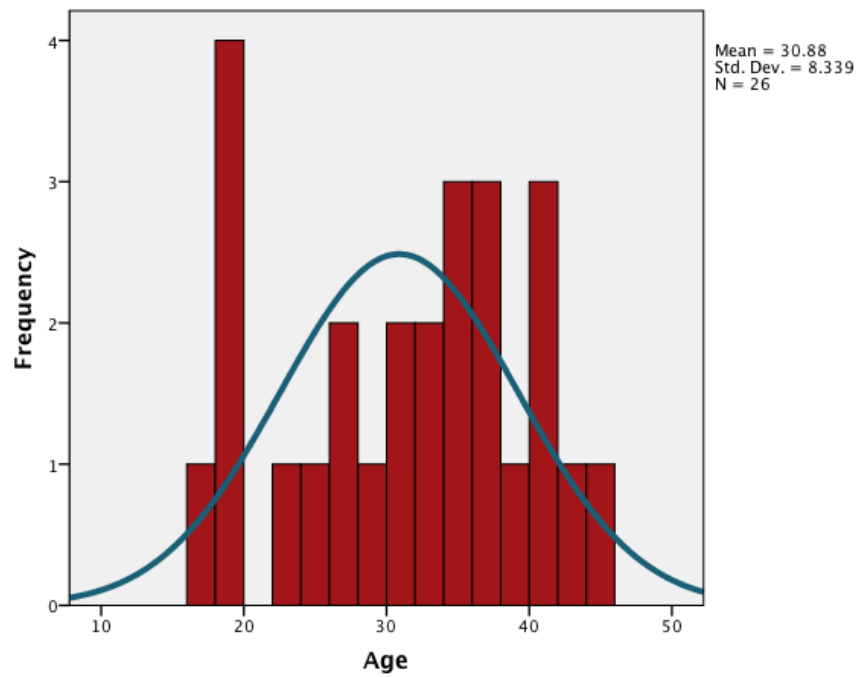
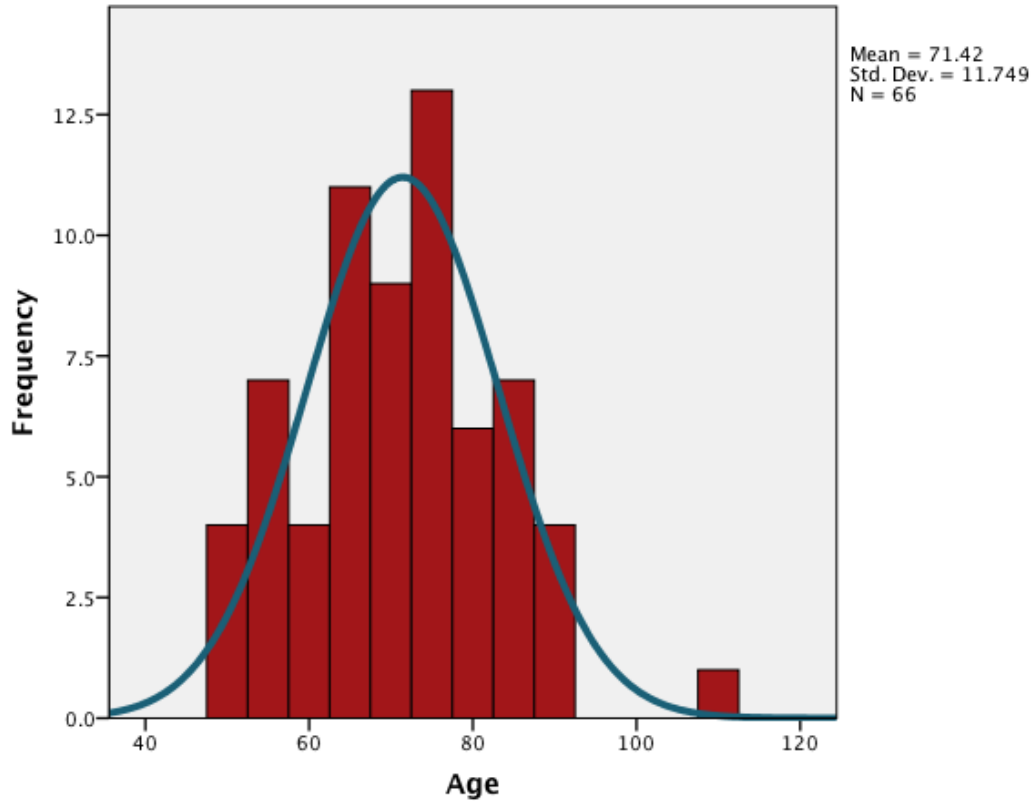


Figure 11. “Seniors”



Additionally, as suspected, some of the bimodal qualities of the items in Tables 15 and 16 are explained by distinct modes between groups. The “Having a Place to be Socially Active” item is a good example of this. Table 17 juxtaposes the frequencies of responses by age group with those of the entire sample for three of the bimodal items in Tables 15 and 16. The response distribution for the entire sample for the “Having a Place to be Socially Active” item is bimodal—out of 124 responses, 51 were “Somewhat Concerned” and 58 were “Very Concerned”. Each of the three age groups has only a single mode. Among the largest group, “Seniors”, 32 of 64 respondents selected “Somewhat Concerned”. *Both* of the two smaller groups, “Youth” and “Adults”, selected “Very Concerned” most frequently (15 out of 24, and 18 out of 26, respectively). Did these groups report different interests

just by chance? Table 17 displays the significance values for all of the items in Tables 15 and 16. As displayed in Table 17, the difference in responses between age groups for the “Having a Place to be Socially Active” item, and for all but one of the other bimodal items, is statistically significant ($\chi^2 = 18.04$, $N = 116$, $df = 6$, $p < .01$).

Table 17. Full Sample & Distinct Age Group Responses for Three Bi-modal Items¹³

	1 Not	2 Somewhat	3 Very	4 N/A
Part/Full time Work				
Full Sample	36	20	31	37
Youth	0	2	6	16
Adults	2	6	16	2
Seniors	32	10	8	16
Having a Place to be Socially Active				
Full Sample	12	51	58	3
Youth	0	8	15	1
Adults	0	8	18	0
Seniors	11	32	22	1
Counseling Services				
Full Sample	33	39	38	13
Youth	3	6	8	7
Adults	4	6	16	0
Seniors	24	25	11	5

Of the nine items in Table 18, only one is definitely not significant (“Social Activities and Relationships”), and one additional item would not be considered significant in pure research, but would probably be considered significant in applied settings, such as this needs assessment.

¹³ Date of birth information was used to calculate a filter variable for separating participants into the three age groups. Some participants did not provide this information, so the sum of frequencies for a particular value in the groups will not be the same as the frequency listed for 'Full Sample'. For example, the sum of 'Not' responses for 'Youth', 'Adults', and 'Seniors' for the 'Part/Full Time Work' item is 34 (32 + 2 + 0), but there were 36 'Not' responses for the 'Full Sample'. This caveat also holds true for frequencies in all the following tables where the three age ranges are broken out and compared with the N for the Full Sample.

Table 18. Differences among Age Groups for Bi-modal Items

	Value	df	Significance
<u>Concern</u>			
Having a Place to be Social	9.57	4	0.048
Having a Place to be Physically Active	13.24	4	0.010
Finding Rehabilitation Services Near Home	7.59	4	0.108
<u>Needs</u>			
Part/Full time Work	54.99	6	0.000
Having a Place to be Socially Active	18.04	6	0.006
Weekend/Evening Rehabilitation Services	13.83	6	0.032
Counseling Services	30.88	6	0.000
<u>Quality of Life</u>			
Health	19.99	8	0.010
Social Activities and Relationships	4.65	8	0.794

Results for all three age groups are reported in the following sections. For simplicity of understanding, tables in each section are labeled with initials representing that section (e.g., the first table in the “Degree of Concern Items” section is labeled DC-1.)

Degree of Concern Items

Table DC-1 displays the frequency of responses for all questionnaire items inquiring about participants’ degree of concern on a number of issues. One can see from a brief scan of the numbers in the table that most of the items have a fairly clear mode (most frequently occurring response), but for three items, responses are split more evenly between two, or even three, choices. For those items, “Having a Place to be Social”, “Having a Place to be Physically Active”, and “Finding Rehabilitation Services Near Home”, multi-modes (*relatively* evenly split responses, each of which appear more frequently than responses in other categories) appear in bold, burgundy text. Single modes appear in bold, plain text for all other items. The same format is used for all following frequency tables in this report.

Table DC-1 Frequency of Responses for Degree of Concern Items

	N	1 Not	2 Somewhat	3 Very	N/A
Health Getting worse	128	24	43	57	4
Having a Place to be Social	128	41	42	39	6
Having a Place to be Physically Active	128	41	31	48	8
Being Able to Get Rehabilitation Services When Needed	128	32	25	66	5
Weekend/Evening Rehabilitation Services Being Offered	128	58	34	28	8
Finding Rehabilitation Services Near Home	128	31	42	48	7
Finding Medical Care Services Near Home	127	35	34	52	6
Achieving/Maintaining Independence	128	20	27	73	8
Having Nurturing/Caring Relationships with Family	128	33	19	71	5
Having Nurturing/Caring Relationships with Friends	128	29	32	62	5
Living in a Safe, Clean Home	128	41	15	69	3
Being Physically Able to Get Around Neighborhood	128	32	26	62	8
Having Transportation to Get Outside Neighborhood	128	43	24	51	4
Being Able to Work Full/Part Time, Paid/Unpaid	128	42	17	33	36
Being Able to Receive Basic Healthcare Services	128	28	30	64	6
Having Equipment (e.g., wheelchair, cane, shower chair)	128	45	20	31	32

Table DC-2a presents, for the three multimodal items, the frequencies from Table DC-1 (entire sample) juxtaposed with frequencies for each of the three identified age groups. Juxtaposed frequencies for uni-modal items appear in Table DC-2b. Note that the N for items in Tables DC-2a and DC-2b may differ from those in DC-1, and N for the three age groups may not add up to the N for all participants, because some responses are lost when selecting cases for age and other filter variables. As is the case for the “Having a Place to be Socially Active” item used as an example in the preceding section, note that the differing distributions of responses for the different age groups account for the multi-modal nature of the frequency distribution for the entire sample. For each of the multi-modal items in Table DC-2a, differing modes (and in some cases, still multi-modes) between age groups creates the bi- or tri-modal distribution that appears in the full sample. Even for some of the items with a single, clear mode, different distribution patterns can be detected between age groups. And, for five out of those eleven items, according to χ^2 significance tests for independence, the difference between the distributions is statistically significant. Differences between groups and χ^2 significance test results for all “Concern” items are presented in table DC-3. Items originally identified as multi-modal for the whole sample appear in bold, burgundy text in this table.

Table DC-2a. Juxtaposition of Responses for Full Sample and for Separate Age Groups on Multimodal Degree of Concern Items

	N	1 Not	2 Somewhat	3 Very
Having a Place to be Social				
Full Sample	122	41	42	39
Youth	23	7	9	7
Adults	23	5	7	14
Seniors	62	24	25	13
Having a Place to be Physically Active				
Full Sample	120	41	31	48
Youth	23	9	7	7
Adults	25	4	4	17
Seniors	62	26	19	17
Finding Rehabilitation Services Near Home				
Full Sample	121	31	42	48
Youth	24	6	9	9
Adults	23	2	10	14
Seniors	61	21	21	19

Table DC-2b. Juxtaposition of Responses for Full Sample and for Separate Age Groups on Unimodal Degree of Concern Items

	N	1 Not	2 Somewhat	3 Very
Health Getting Worse				
Full Sample	114	23	39	52
Youth	22	4	10	5
Adults	23	3	3	14
Seniors	66	13	23	30
Being Able to Get Rehabilitation Services When Needed				
Full Sample	112	30	21	31
Youth	23	6	5	12
Adults	25	2	4	19
Seniors	64	22	12	30
Weekend/Evening Rehabilitation Services Being Offered				
Full Sample	110	53	31	23
Youth	23	9	8	6
Adults	24	8	7	9
Seniors	63	36	16	11
Finding Medical Care Services Near Home				
Full Sample	112	34	31	44
Youth	24	8	6	10

Adults	25	2	10	13
Seniors	63	24	15	24
Living in a Safe, Clean Home				
Full Sample	114	34	11	33
Youth	23	10	1	12
Adults	23	5	4	17
Seniors	65	22	6	37
Being Physically Able to Get Around Neighborhood				
Full Sample	110	30	22	58
Youth	20	7	4	9
Adults	25	4	5	16
Seniors	65	19	13	33
Being Able to Work Full/Part Time, Paid/Unpaid				
Full Sample	84	40	14	30
Youth	9	4	0	5
Adults	25	4	4	17
Seniors	50	32	10	8
Being Able to Receive Basic Healthcare Services				
Full Sample	112	24	24	58
Youth	23	9	3	11
Adults	23	1	9	16
Seniors	63	17	15	31
Having Nurturing/Caring Relationships with Family				
Full Sample	112	30	15	34
Youth	22	9	2	11
Adults	26	3	4	19
Seniors	64	18	9	37
Having Nurturing/Caring Relationships with Friends				
Full Sample	114	24	29	58
Youth	23	6	4	13
Adults	26	3	5	18
Seniors	65	18	20	27
Having Equipment (e.g., wheelchair, cane, shower chair)				
Full Sample	87	42	17	28
Youth	12	8	2	2
Adults	18	8	3	7
Seniors	57	26	12	19

Items listed below the broken line in Table DC-3 would not be considered statistically significant in pure research, where $p < .05$ is often treated as the threshold. In applied settings, like this needs assessment, however, $p < .10$ is frequently treated as the threshold. By that standard, the

first item under the broken line, “Finding Medical Care Services Near Home” would also be significant. Groups differ most significantly regarding concerns for “Being Able to Work Full/Part Time” ($p < .001$) and “Having a Place to be Physically Active” ($p = .01$, approximately). This latter result has direct relevance, because one of the recommendations in the final report addresses facilities for physical fitness activities. Any action taken on that recommendation should bear in mind that most “Seniors” are not concerned about this issue.

Table DC-3. Differences among Age Groups for Concern Items

	Value	df	Significance
Being Able to Work Full/Part Time, Paid/Unpaid	23.355	4	0.000
Having a Place to be Physically Active	13.24	4	0.010
Health Getting Worse	8.935	4	0.032
Having Transportation to Get Outside Neighborhood	10.331	4	0.035
Achieving/Maintaining Independence	8.588	4	0.042
Being Able to Receive Basic Healthcare Services	9.483	4	0.044
Having a Place to be Social	9.542	4	0.048
Finding Medical Care Services Near Home	8.023	4	0.091
Being Able to Get Rehabilitation Services When Needed	4.412	4	0.103
Finding Rehabilitation Services Near Home	4.59	4	0.108
Having Nurturing/Caring Relationships with Friends	3.802	4	0.144
Weekend/Evening Rehabilitation Services Being Offered	3.103	4	0.192
Having Nurturing/Caring Relationships with Family	5.502	4	0.240
Being Physically Able to Get Around Neighborhood	2.540	4	0.332
Living in a Safe, Clean Home	4.231	4	0.342
Having Equipment (e.g., wheelchair, cane, shower chair)	2.345	4	0.343

Needs and Their Importance Items

Following the same pattern as the tables in the previous section, the first three tables in this section present frequencies for “Need” items from the questionnaire. Table NI-1 presents frequencies for the entire sample, including “Not Applicable” responses, for all items. Tables NI-2a and NI-2b present frequencies for the different age groups juxtaposed with the frequencies for the entire sample, for the multi-modal and single mode items, respectively.

Table NI-1. Frequency of Responses for Needs and Their Importance Items

	N	1 Not	2 Somewhat	3 Very	N/A
Adequate Transportation	124	10	28	74	12
Part/Full time Work	124	36	20	31	37
Socializing with Others	124	4	44	70	3
Having a Place to be Socially Active	124	12	51	58	3
Recreation Opportunities	124	17	43	60	4
Caregiver Services	124	23	35	53	13
Weekend/Evening Rehabilitation Services	124	41	41	34	8
Being Physically Able to Get Around Neighborhood	124	16	30	68	10
Being Physically Able to Get Outside Neighborhood	124	13	38	62	11
Counseling Services	123	33	39	38	13
Living Independently	124	10	20	81	13
Housing Adapted for Persons with Disabilities	124	16	30	56	22
Access to Healthcare Services	124	8	18	94	4
Access to Physical Fitness Activities	124	10	36	72	3
Educational Programs	124	26	29	65	4
Having Equipment (e.g., wheelchair, cane, shower chair)	123	23	22	48	30
Adequate Health Insurance	124	9	7	106	2

Table NI-2a. Juxtaposition of Responses for Full Sample and for Age Groups on Multimodal Needs and Their Importance Items

	N	1 Not	2 Somewhat	3 Very
Part/Full time Work				
Full Sample	124	36	20	31
Youth	24	0	2	6
Adults	26	2	6	16
Seniors	66	32	10	8
Having a Place to be Socially Active				
Full Sample	124	12	51	58
Youth	24	0	8	15
Adults	26	0	8	18
Seniors	66	11	32	22
Weekend/Evening Rehabilitation Services				
Full Sample	124	41	41	34
Youth	24	6	6	10
Adults	26	3	13	9
Seniors	66	30	17	15
Counseling Services				
Full Sample	123	33	39	38

Youth	24	3	6	8
Adults	26	4	6	16
Seniors	65	24	25	11

Again, fairly clear differences in preferences emerge between the groups for each of the multi-modal items. Differences between groups on single mode items are less clear.

Table NI-2b. Juxtaposition of Responses for Full Sample and for Age Groups on Uni-modal Needs and Their Importance Items

	N	1 Not	2 Somewhat	3 Very
Adequate Transportation				
Full Sample	124	10	28	74
Youth	24	0	4	14
Adults	26	2	7	16
Seniors	66	7	15	40
Socializing with Others				
Full Sample	124	4	47	70
Youth	24	0	4	18
Adults	26	0	9	17
Seniors	66	4	30	32
Recreation Opportunities				
Full Sample	124	14	43	60
Youth	24	1	7	16
Adults	26	0	7	19
Seniors	66	16	25	22
Caregiver Services				
Full Sample	124	23	35	53
Youth	24	1	8	10
Adults	26	5	9	10
Seniors	66	16	13	32
Being Physically Able to Get Around Neighborhood				
Full Sample	124	16	30	68
Youth	24	1	6	10
Adults	26	2	4	19
Seniors	66	12	17	36
Being Physically Able to Get Outside Neighborhood				
Full Sample	124	13	38	62
Youth	24	1	8	8
Adults	26	2	7	16
Seniors	66	8	21	35
Living Independently				

Full Sample	124	10	20	81
Youth	24	1	2	12
Adults	26	1	2	23
Seniors	66	8	15	40
Housing Adapted for Persons with Disabilities				
Full Sample	124	16	30	56
Youth	24	2	6	6
Adults	26	1	7	15
Seniors	66	12	14	32
Access to Healthcare Services				
Full Sample	124	8	18	94
Youth	24	2	3	18
Adults	26	0	4	22
Seniors	66	5	10	50
Access to Physical Fitness Activities				
Full Sample	124	10	36	72
Youth	24	1	6	16
Adults	26	0	7	19
Seniors	66	8	22	33
Educational Programs				
Full Sample	124	26	29	65
Youth	24	2	2	20
Adults	26	2	3	21
Seniors	66	20	23	21
Having Equipment (e.g., wheelchair, cane, shower chair)				
Full Sample	124	23	22	48
Youth	24	4	1	4
Adults	26	5	6	9
Seniors	65	13	14	32
Adequate Health Insurance				
Full Sample	124	9	7	106
Youth	24	2	2	20
Adults	26	0	1	25
Seniors	66	6	3	57

Differences between groups and χ^2 significance test results for all items are presented in table NI-3. Items originally identified as bimodal for the whole sample appear in bold, burgundy text. Items listed below the broken line would not be considered statistically significant by pure research standards, where $p < .05$ is often treated as the threshold. The first item under the broken line however, “Adequate Transportation”, does meet the applied research standard for statistical significance ($p < .10$). Despite differences being less obvious in the juxtaposed frequencies in Tables

NI-2a and NI-2b than they were in Tables DC-2a and DC-2b, groups differ significantly on more “Needs” items than they do on “Concern” items. Based on a visual review of the data in Tables NI-2a and NI-2b, it appears that these differences are explained more by degree of preference than by direction. In other words, it appears that while groups as a whole appear to agree on most items (particularly in NI-2b), there is variation in the number of members responding in like manner within groups.

Table NI-3. Differences Among Age Groups for Needs Items

	Value	df	Significance
Being Physically Able to Get Around Neighborhood	24.549	3	0.000
Educational Programs	29.103	3	0.000
Having Equipment (e.g., wheelchair, cane, shower chair)	29.534	3	0.000
Part/Full time Work	54.990	3	0.000
Counseling Services	30.880	3	0.000
Living Independently	31.135	3	0.000
Recreation Opportunities	20.454	3	0.002
Having a Place to be Socially Active	18.040	3	0.003
Being Physically Able to Get Outside Neighborhood	18.409	3	0.005
Socializing with Others	14.133	3	0.009
Housing Adapted for Persons with Disabilities	13.225	3	0.013
Caregiver Services	13.830 ^a	3	0.032
Weekend/Evening Rehabilitation Services	13.830	3	0.032
Adequate Transportation	10.948	3	0.090
Access to Physical Fitness Activities	4.449	3	0.254
Access to Healthcare Services	3.343	3	0.424
Adequate Health Insurance	3.204	4	0.524

Of perhaps immediate relevance are the differences between group responses for the availability of evening and weekend rehabilitation services. Most of the responses among the entire sample for this item are split between “Not Important” and “Somewhat Important” (41 responses each). Broken into groups, the most frequent response is different for each group. “Seniors” and “Adults” more often answer that this issue is not, or is only somewhat, important, while members of the smallest group, “Youth”, report this issue as “Very Important” more frequently than they do for

the other options. In short, the availability of evening and weekend rehabilitation services is important for a small group, composed mostly of younger patients.

Quality of Life Items

Following essentially the same format as the previous sections, tables QL-1a, QL-1b, QL-2a, and QL-1b present the frequencies for the entire sample and for the different age groups juxtaposed with the entire sample, respectively.

Table QL-1a. Frequency of Responses for Quality of Life Items

Questionnaire Item	N	Excellent	Very Good	Good	Fair	Poor
Health	123	14	25	33	34	14
QoL	123	25	23	38	24	10
Social Activities and Relationships	123	24	26	38	24	11

Table QL-1b. Frequency of Responses for Two Quality of Life Items

	N	Completely	Mostly	Moderately	A Little	Not at All
Ability to Carry Out Everyday Activities	122	49	24	21	17	11
		Never	Rarely	Sometimes	Often	Always
Frequency of Emotional Problems	122	21	26	41	26	8

The greatest differences in responses between groups concerning “Quality of Life” items occur for their ratings of their health. Perhaps not surprisingly, “Seniors” report a lower rating for their health than do the other two groups. Interestingly, the responses for all three groups, and for the entire sample, on this item are bimodal. “Seniors” are split between “Good” and “Fair”, “Adults”, slightly more positive, are split three ways between the “Very Good”, “Good”, and “Fair”. “Youth” rate their health most positively, split between “Excellent” and “Very Good”.

Table QL-2a. Juxtaposition of Full Sample and Group Responses for Three Quality of Life Items

	N	1 Excellent	2 Very Good	3 Good	4 Fair	5 Poor
Health						
Full Sample	123	17	25	33	34	14
Youth	24	8	9	4	3	0
Adults	26	3	6	6	7	4

Seniors	66	6	9	21	22	8
Quality of Life						
Full Sample	123	25	26	38	24	10
Youth	24	11	5	8	0	0
Adults	26	2	5	11	6	2
Seniors	66	11	15	19	15	6
Social Activities and Relationships						
Full Sample	123	24	26	38	24	11
Youth	24	5	7	7	5	0
Adults	26	4	5	8	7	2
Seniors	66	14	14	22	10	6

Table QL-2b. Juxtaposition of Full Sample and Group Responses for Two Quality of Life Items

	N	1 Completely	2 Mostly	3 Moderately	4 A Little	5 Not at All
Ability to Carry Out Everyday Activities						
Full Sample	122	49	24	21	17	11
Youth	23	13	8	0	0	2
Adults	26	14	3	5	3	1
Seniors	66	21	11	14	13	7
	N	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
Frequency of Emotional Problems						
Full Sample	122	21	26	41	26	8
Youth	23	7	4	6	6	0
Adults	26	2	4	12	4	4
Seniors	66	12	17	19	15	3

According to the results of a χ^2 test for independence ($\chi^2 = 19.99$, $df = 8$, $p = .01$, approximately), this difference is unlikely to be an accident attributable to this particular sample (i.e., sampling bias). Two additional “Quality of Life” items are also significant. Results for all “Quality of Life” items are presented in Tables QL-3a and QL-3b.

Table QL-3a. Differences among Age Groups for Quality of Life Items

	Value	df	Significance
Health	19.99	8	0.010
Quality of Life	18.45	8	0.013
Social Activities and Relationships	4.35	8	0.494

Table QL-3b. Differences among Age Groups for Two Quality of Life Items

	Value	df	Significance
Ability to Carry Out Everyday Activities	18.28	8	0.019
Frequency of Emotional Problems	12.44	8	0.120

Conclusions

Having established statistically significant differences between the groups, let us adopt for each group the macro view taken in the final report for the full sample. Recall that “Being Able to Receive Rehabilitation Services When Needed” and “Health Getting Worse” were consistently ranked high among “Concerns” across the reporting years (2003, 2009, and 2012). “Being Able to Receive Rehabilitation Services When Needed” also ranks high across groups—this appears to be of great concern regardless of age group. Though not ranking quite as high for two of the groups (“Adults” and “Youth”) “Health Getting Worse” is still an issue of substantial importance for “Adults” and “Seniors”, each of which selected “Very Concerned” more often than other response options. “Youth”, on the other hand, selected “Somewhat Concerned” most often.

In terms of needs considered important, for the entire sample, “Counseling Services” ranked among the least important needs in all three studies, and “Being Able to Work Full/Part Time” ranked among the least important for the last two studies (2009 and 2012). “Adequate Health Insurance” was the highest ranked need and “Access to Health Care Facilities” the second highest, in the community needs assessment for 2003, 2009, and 2012. The high ranking of “Adequate Health Insurance” and “Access to Health Care Facilities” is also consistent across groups for this year’s needs assessment. The low rankings for “Counseling Services” and “Being Able to Work Full/Part Time” however, are skewed by the preferences of the larger “Seniors” group. While members of that group most frequently select “Not Important”, the most frequent response for these items in the two smaller groups is “Very Important”.

Finally, as indicated in the “Concerns” section and the “Needs” section, respectively, responses regarding concerns about physical fitness facilities and the importance (“Needs”) of evening and weekend rehabilitation services appear to have the most direct, immediate relevance for recommendations offered in the final report. “Seniors” most often reported that they are “Not Concerned” about having a place to be physical active, in contrast to the other two groups, each of which most frequently selects “Very Concerned” about such access. A similar pattern emerged for “Youth” regarding the need for evening and weekend rehabilitation services. This group, in contrast to the other two, most frequently reported these services as “Very Important”. Thus, while such services do not appear to be very important for the general population, this younger sub-population does consider them very important.

This analysis of group differences, though immediately relevant for only a couple of items, nonetheless reveals important and statistically significant differences in needs and preferences between three age groups served by Casa Colina Rehabilitative Hospital. Thus, to accurately assess the needs of the community of persons with disabilities or at risk for disability, Casa Colina should consider these group differences for future assessments.