Community Health Needs Assessment Implementation and Action Plan

Adopted by Barton Health's Board of Directors on September 24, 2015

Barton Health

2015 Community Health Needs Assessment

In the spring of 2015, Barton Health embarked on a comprehensive Community Health Needs Assessment (CHNA) process to identify and address the key health issues for our community.

Barton Memorial Hospital, based in South Lake Tahoe, CA, is a not-for-profit, 112-bed hospital (acute care and skilled nursing) with a primary service area surrounding South Lake Tahoe, CA and Douglas County, NV. In addition to the hospital, Barton Health (Barton) manages an additional 17 physician offices and clinic practices. With nearly 900 employees, Barton provides services primarily to residents of the South Lake Tahoe area, but also serves those around the Lake and Carson Valley as well as a large number of visitors to the area. Barton Memorial Hospital is accredited by The Joint Commission.

Barton Health's mission is to deliver safe, high quality care and engage the community in the improvement of health and wellness. The vision is to be the community health leader known for compassion and chosen for quality. Barton is committed to integrity, collaboration and excellence through the practice of our four Service Standards: Safety, Respect, Image, and Efficiency.

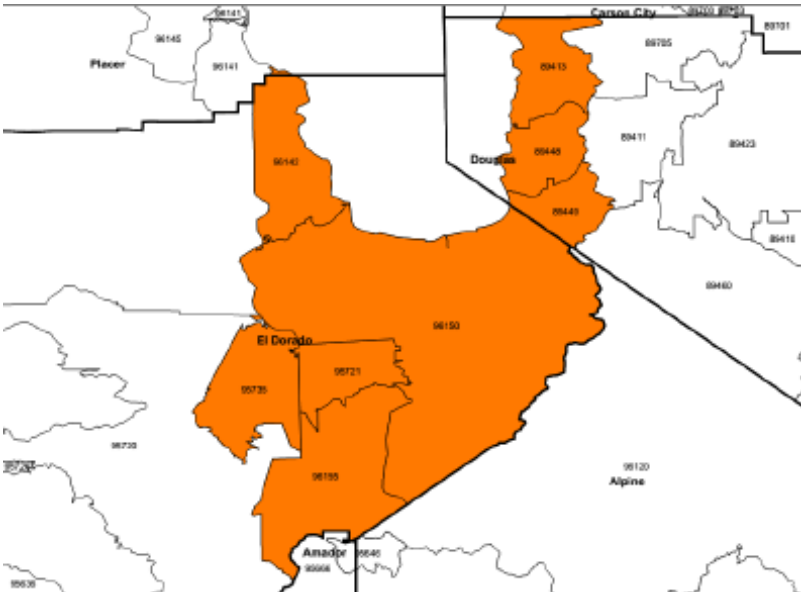
Definition of the Community Served

[IRS Form 990, Schedule H, Part V, Section B, 1a

Barton Health completed its last Community Health Needs Assessment in spring 2012. Comparative results are available.

CHNA Community Definition

The study area for the survey effort (referred to as the "Primary Service Area" in this report) includes these residential ZIP Codes: 95721, 95735, 96142, 96150, 96151, 96155, 96158, 89413, 89448 and 89449. A geographic description is illustrated in the following map. This community definition was determined because the majority of Barton's patients originate from this area.

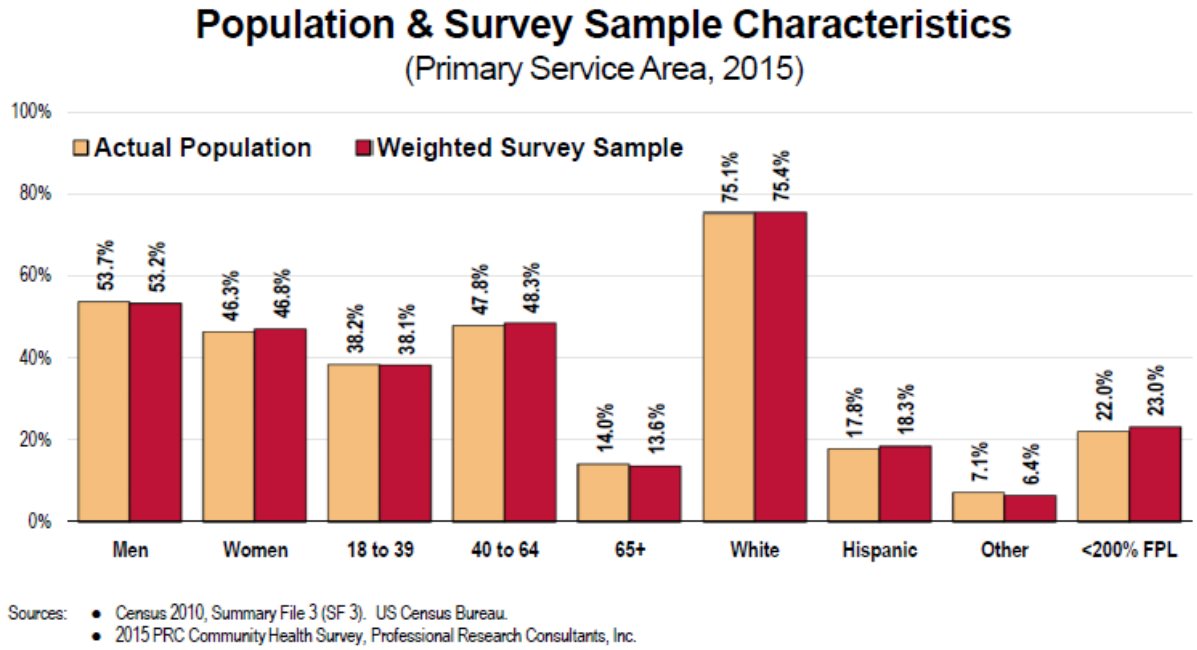


Demographics of the Community

[IRS Form 990, Schedule H, Part V, Section B, 1b]

To accurately represent the population studied, PRC strives to minimize bias through application of a proven telephone methodology and random-selection techniques. While this random sampling of the population produces a highly representative sample, it is a common and preferred practice to "weight" the raw data to improve this representativeness even further. This is accomplished by adjusting the results of a random sample to match the geographic distribution and demographic characteristics of the population surveyed (poststratification), so as to eliminate any naturally occurring bias. Specifically, once the raw data is gathered, respondents are examined by key demographic characteristics (namely gender, age, race, ethnicity, and poverty status) and a statistical application package applies weighting variables that produce a sample which more closely matches the population for these characteristics. Thus, while the integrity of each individual's responses is maintained, one respondent's responses may contribute to the whole the same weight as, for example, 1.1 respondents. Another respondent, whose demographic characteristics may have been slightly oversampled, may contribute the same weight as 0.9 respondents.

The following charts outline the characteristics of the Primary Service Area sample for key demographic variables, compared to actual population characteristics revealed in census data. [Note that the sample consisted solely of area residents age 18 and older; data on children were given by proxy by the person most responsible for that child's healthcare needs, and these children are not represented demographically in this chart.]



Sources:
- Census 2010, Summary File 3 (SF 3). US Census Bureau.
- 2015 PRC Community Health Survey, Professional Research Consultants, Inc.

Further note that the poverty descriptions and segmentation used in this report are based on administrative poverty thresholds determined by the US Department of Health & Human Services. These guidelines define poverty status by household income level and number of persons in the household *(e.g., the 2012 guidelines place the poverty threshold for a family of four at $23,050 annual household income or lower)*. In sample segmentation: "**low income**" refers to community members living in a household with defined poverty status or living just above the poverty level, earning up to twice the poverty threshold; "**mid/high income**" refers to those households living on incomes which are twice or more the federal poverty level.

Resources Available to Address the Significant Health Needs

[IRS Form 990, Schedule H, Part V, Section B, 1c]

The following represent potential measures and resources (such as programs, organizations, and facilities in the community) available to address the significant health needs identified in this report. This list is not exhaustive, but rather outlines those resources identified in the course of conducting this Community Health Needs Assessment.

Access to Healthcare Services

- *AA/NA Groups*
- *Barton Community Health Center*
- *Barton Memorial Hospital*
- *Barton Infusion Center*
- *El Dorado County Mental Health*
- *Covered California*
- *El Dorado County Health Department*
- *Emergency Department*
- *First Five*
- *Lake Tahoe Collaborative*
- *Local Dentists*
- *Medi-Cal*
- *NAMI*
- *Nonprofit Organizations*
- *OPEN*
- *Private Insurance Brokers*
- *Public Health Department*
- *Schools*
- *Sierra and Family Services*
- *South Lake Tahoe Cancer League*
- *Tahoe Magic*
- *Tahoe Transportation District Mobility Manager*
- *Urgent Care*

Arthritis, Osteoporosis & Chronic Back Conditions

- *Acupuncturist*
- *Barton Community Health Center*
- *Tahoe Center for Orthopedics*

Cancer

- *Barton Home Health and Hospice*
- *Barton Memorial Hospital*
- *Barton Infusion Center*
- *Carson Tahoe Cancer Center*
- *Dr. Heifetz*
- *Dr. Perez*
- *Part-time Oncologist*
- *South Lake Tahoe Cancer League*
- *Tahoe Forest Hospital*
- *Tele-Medicine Conference with Barton Healthcare*

Chronic Kidney Disease

- *Lack of Services Locally*

Dementias, Including Alzheimer's Disease

- *Barton Skilled Nursing*
- *Dr. Sullivan*
- *Support Groups at the Senior Center*

Diabetes

- *Barton Community Health Center*
- *Barton Health*
- *Barton Memorial Hospital*
- *Bike the West Tour de Tahoe*
- *Local Doctors*
- *Urgent Care*
- *Weight Watchers*

Family Planning

- *Barton Community Health Center*
- *Barton Women's Health*

- *Local Doctors*
- *El Dorado County Public Health Department*
- *Emerald Bay Center for Women's Health*
- *Mount Tallac School*
- *Patty Murphy from the Health Department*
- *School Nurse*
- *Tahoe Youth and Family Services*

Hearing & Vision

- *Barton ENT*
- *CCS Referral for Hearing Evaluation*
- *Health Department*
- *Lake Tahoe Eye Care*
- *School Nurse*
- *Sight for Students Program*

Heart Disease & Stroke

- *Acupuncture*
- *Barton Health Seminars*
- *Local Doctors*
- *Dr. Young*

Immunization & Infectious Diseases

- *Barton Pediatrics*

Infant & Child Health

- *Barton Community Health Center*
- *Barton Pediatrics*
- *El Dorado County Health Department*
- *Family Resource Center*
- *First Five*
- *Midwives*
- *Mobile Dental*
- *School Nurse*

Injury & Violence

- *Barton Community Health Center*
- *Barton Memorial Hospital*
- *Local Doctors*
- *El Dorado County Mental Health*
- *El Dorado County Sheriff's Office*
- *Family Resource Center*
- *Live Violence Free*
- *South Lake Tahoe Police Department*
- *Tahoe Turning Point*
- *Tahoe Youth and Family Services*

Mental Health

- *A Balanced Life*
- *Alcoholics Anonymous*
- *Barton Community Health Center*
- *Barton Health*
- *City of South Lake Tahoe Police Dept.*
- *Department of Rehabilitation*
- *Dr. Protell and Dr. Rupp*
- *El Dorado County Human Services*
- *El Dorado County Mental Health*
- *El Dorado County Sheriff Dept.*
- *Emergency Room*
- *Family Resource Center*
- *Justice System*
- *Live Violence Free*
- *National Alliance on Mental Illness*
- *Private Therapists*
- *Tahoe Magic, Salvation Army, Section 8*
- *Tahoe Turning Point*
- *Tahoe Youth and Family Services*
- *Telehealth Access*
- *Psychiatric Facilities*

Nutrition, Physical Activity & Weight

- *Boys and Girls Club*
- *Christmas Cheer*
- *Family Resource Center*
- *First 5*
- *Lake Tahoe Bicycle Coalition*
- *Lake Tahoe Community College*
- *LTUSD*
- *PAL*
- *Private Gyms*
- *Private Yoga Studios*
- *Rec Center*
- *UC Davis Nutrition Classes*

Oral Health

- *Barton Community Health Clinic*
- *Community-Minded Dentists*
- *Dr. Mireya Ortega*
- *First 5 Dental Van*
- *OPEN*
- *School Nurse*
- *School Programs for Dental Health*
- *Tahoe Magic*

Respiratory Diseases

- *Radon Testing and Mitigation Services*
- *Tahoe Urgent Care*

Sexually Transmitted Diseases

- *Barton Community Health Center*
- *High Schools*
- *School Nurse*

Substance Abuse

- *Alcoholics Anonymous*
- *Barton Community Advisory Committee*
- *Youth Advisory Council in Schools*
- *Barton Community Health Center*
- *Barton Health*
- *Court Mandated Treatment*
- *El Dorado County Alcohol and Drug Program*
- *El Dorado County Drug Court Program*
- *El Dorado County Health and Human Services*
- *Emergency Room*
- *Family Resource Center*
- *Jail*
- *Lake Tahoe Unified School District*
- *Live Violence Free*
- *Narcotics Anonymous*
- *SLEDNET*
- *SOS Outreach*
- *South Lake Tahoe Drug Free Coalition*
- *South Lake Tahoe Police Department*
- *Tahoe Turning Point*
- *Tahoe Youth and Family Services*

Tobacco Use

- *Anti-Smoking Laws for Indoor Smoking*
- *Barton Health Cessation Program*
- *Barton University*
- *EDC Health Department*
- *Keep Tahoe Blue*
- *NA/AA*
- *Red Ribbon Week*
- *Tahoe Turning Point*
- *Youth Advisory Council in Schools*

- *Doctor's Office*

El Dorado County Health Department

El Dorado County Mental Health Department

Emergency Department

First Five

Lake Tahoe Collaborative

How CHNA Data Was Obtained [IRS Form 990, Schedule H, Part V, Section B, 1d]

Collaboration [IRS Form 990, Schedule H, Part V, Section B, 4]

This Community Health Needs Assessment (CHNA) was sponsored by Barton Health and Barton Memorial Hospital, in collaboration with the Community Health Advisory Committee. This project received input and guidance form these sources throughout the process.

CHNA Goals & Objectives

This Community Health Needs Assessment is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area (PSA) of Barton Health and Barton Memorial Hospital. Subsequently, this information may be used to inform decisions and guide efforts to improve community health and wellness.

A Community Health Needs Assessment provides information so that communities may identify issues of greatest concern and decide to commit resources to those areas, thereby making the greatest possible impact on community health status. This Community Health Needs Assessment will serve as a tool toward reaching three basic goals:

To improve residents' health status, increase their life spans, and elevate their overall quality of life. A healthy community is not only one where its residents suffer little from physical and mental illness, but also one where its residents enjoy a high quality of life.

To reduce the health disparities among residents. By gathering demographic information along with health status and behavior data, it will be possible to identify population segments that are most at-risk for various diseases and injuries. Intervention plans aimed at targeting these individuals may then be developed to combat some of the socio-economic factors which have historically had a negative impact on residents' health.

To increase accessibility to preventive services for all community residents. More accessible preventive services will prove beneficial in accomplishing the first goal (improving health status, increasing life spans, and elevating the quality of life), as well as lowering the costs associated with caring for late-stage diseases resulting from a lack of preventive care.

This assessment was conducted on behalf of Barton Health by Professional Research Consultants, Inc. (PRC). PRC is a nationally-recognized healthcare consulting firm with extensive experience conducting Community Health Needs Assessments such as this in hundreds of communities across the United States since 1994.

CHNA Methodology

This assessment incorporates data from both quantitative and qualitative sources. Quantitative data input includes primary research (the PRC Community Health Survey) and secondary research (vital statistics and other existing health-related data); these quantitative components allow for trending and comparison to benchmark data at the state and national levels. Qualitative data input includes primary research gathered through an online Key Informant survey.

Public Health, Vital Statistics & Other Data

A variety of existing (secondary) data sources was consulted to complement the research quality of this Community Health Needs Assessment. Data for the Primary Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Center for Applied Research and Environmental Systems (CARES)
- Centers for Disease Control & Prevention, Office of Infectious Disease, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention
- Centers for Disease Control & Prevention, Office of Public Health Science Services, Center for Surveillance, Epidemiology and Laboratory Services, Division of Health Informatics and Surveillance (DHIS)
- Centers for Disease Control & Prevention, Office of Public Health Science Services, National Center for Health Statistics
- Community Commons
- ESRI ArcGIS Map Gallery
- National Cancer Institute, State Cancer Profiles
- OpenStreetMap (OSM)
- US Census Bureau, American Community Survey
- US Census Bureau, County Business Patterns
- US Census Bureau, Decennial Census
- US Department of Agriculture, Economic Research Service
- US Department of Health & Human Services
- US Department of Health & Human Services, Health Resources and Services Administration (HRSA)
- US Department of Justice, Federal Bureau of Investigation
- US Department of Labor, Bureau of Labor Statistics

Note that secondary data reflect county-level data for El Dorado County (California) and Douglas County (Nevada).

Community Health Survey

A precise and carefully executed methodology is critical in asserting the validity of the results gathered in the *PRC Community Health Survey*. Thus, to ensure the best representation of the population surveyed, a telephone interview methodology — one that incorporates both landline and cell phone interviews — was employed. The primary advantages of telephone interviewing are timeliness, efficiency and random-selection capabilities.

The sample design used for this effort consisted of a random sample of 400 individuals age 18 and older in the Primary Service Area. Once the interviews were completed, these were weighted in proportion to the actual population distribution so as to appropriately represent the Primary Service Area as a whole. All administration of the surveys, data collection and data analysis was conducted by Professional Research Consultants, Inc. (PRC).

Community Stakeholder Input

[IRS Form 990, Schedule H, Part V, Section B, 1h & 3]

To solicit input from key informants, those individuals who have a broad interest in the health of the community, an Online Key Informant Survey was also implemented as part of this process. A list of recommended participants was provided by Barton Health; this list included names and contact information for physicians, public health representatives, other health professionals, social service providers, and a variety of other community leaders. Potential participants were chosen because of their ability to identify primary concerns of the populations with whom they

work, as well as of the community overall.

Key informants were contacted by email, introducing the purpose of the survey and providing a link to take the survey online; reminder emails were sent as needed to increase participation. In all, 44 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Key Informant Type	Number Invited	Number Participating
Physician	16	1
Other Health Provider	19	5
Public Health Expert	7	5
Social Services Representative	21	15
Community Leader	35	17
Other/Unknown	3	1
TOTAL:		44

NOTE: These findings represent qualitative rather than quantitative data. The Online Key Informant Survey was designed to gather input from participants regarding their opinions and perceptions of the health of the residents in the area. Thus, these findings are based on perceptions, not facts.

Information Gaps

[IRS Form 990, Schedule H, Part V, Section B, 1i]

While this assessment is quite comprehensive, it cannot measure all possible aspects of health in the community, nor can it adequately represent all possible populations of interest. It must be recognized that these information gaps might in some ways limit the ability to assess all of the community's health needs.

For example, certain population groups — such as the homeless, institutionalized persons, or those who only speak a language other than English or Spanish — are not represented in the survey data. Other population groups — for example, pregnant women, lesbian/gay/bisexual/transgender residents, undocumented residents, and members of certain racial/ethnic or immigrant groups — might not be identifiable or might not be represented in numbers sufficient for independent analyses.

In terms of content, this assessment was designed to provide a comprehensive and broad picture of the health of the overall community. However, there are certainly a great number of medical conditions that are not specifically addressed.

Vulnerable Populations

[IRS Form 990, Schedule H, Part V, Section B, 1f]

The CHNA analysis and report yielded a wealth of information about the health status, behaviors and needs for our population. A distinct advantage of the primary quantitative (survey) research is the ability to segment findings by geographic, demographic and health characteristics to identify the primary and chronic disease needs and other health issues of vulnerable populations, such as uninsured persons, low-income persons, and racial/ethnic minority groups.

For additional statistics about uninsured, low-income, and minority health needs please refer to the complete PRC Community Health Needs Assessment report, which can be viewed online at http://southlaketahoe.healthforecast.net/.

Public Dissemination

[IRS Form 990, Schedule H, Part V, Section B, 5-5c]

This Community Health Needs Assessment is available to the public using the following URL: http://southlaketahoe.healthforecast.net/. HealthForecast.net™ is an interactive, dynamic tool designed to share CHNA data with community partners and the public at large.

This site:

- Informs readers that the CHNA Report is available and provides instructions for downloading it;
- Offers the CHNA Report document in a format that, when accessed, downloaded, viewed, and printed in hard copy, exactly reproduces the image of the report;
- Grants access to download, view, and print the document without special computer hardware or software required for that format (other than software that is readily available to members of the public without payment of any fee) and without payment of a fee to the hospital organization or facility or to another entity maintaining the website.

Barton Health will provide any individual requesting a copy of the written report with the direct website address, or URL, where the document can be accessed. Barton will also maintain at its facilities a hardcopy of the CHNA report that may be viewed by any who request it.

Health Needs of the Community

[IRS Form 990, Schedule H, Part V, Section B, 1e]

After reviewing the Community Health Needs Assessment findings, the CHNA Steering Committee met on April 17, 2015 to determine the health needs to be prioritized for action. During the a detailed presentation of the CHNA findings, consultants from PRC used audience response system (ARS) technologies to lead steering committee members through a process of understanding key local data findings (Areas of Opportunity) and ranking identified health issues against the following established, uniform criteria:

- **Magnitude.** The number of persons affected, also taking into account variance from benchmark data and Healthy People 2020 targets.

- **Impact/Seriousness.** The degree to which the issue affects or exacerbates other quality of life and health-related issues.
- **Feasibility.** The ability to reasonably impact the issue, given available resources.
- **Consequences of Inaction.** The risk of not addressing the problem at the earliest opportunity.

From this exercise, the Areas of Opportunity were prioritized as follows by the committee:

Areas of Opportunity Identified Through This Assessment	
1. Mental Health	• Suicide Deaths • Seeking Help for Mental Health • *Mental Health ranked #2 as a "major problem" in the Online Key Informant Survey*
2.Substance Abuse	• Cirrhosis/Liver Disease Deaths • Overall Alcohol Use • Excessive Drinking • Drinking & Driving • Drug-Induced Deaths • *Substance Abuse ranked #1 as a "major problem" in the Online Key Informant Survey*
3. Access to Healthcare Services	• Specific Source for Healthcare • Barriers to Access o Appointment Availability o Finding a Physician • Primary Care Physician Ratio • Health Professional Shortage Area Designation
4. Heart Disease & Stroke	• *Heart Disease is the #2 Leading Cause of Death in the Area*
5. Oral Health	• *Oral Health ranked #3 as a "major problem" in the Online Key Informant Survey*
6. Infant Health	• Prenatal Care
7. Injury & Violence	• Unintentional Injury Deaths o Including Motor Vehicle Crash Deaths • Firearm-Related Deaths
8. Nutrition, Physical Activity & Weight	• Fruit/Vegetable Consumption • Low Food Access • Obesity • Medical Advice on Weight
9. Cancer	• *Cancer is the #1 Leading Cause of Death in the Area* • Cancer Incidence o Including Lung Cancer, Prostate Cancer, Female Breast Cancer

	• Skin Cancer Prevalence
10. Tobacco Use	• Chronic Lower Respiratory Disease (CLRD) Deaths • Use of Cigars • Use of Smokeless Tobacco
11. Dementia, Including Alzheimer's Disease	• Alzheimer's Disease Deaths

Community-Wide Benefit Planning

[IRS Form 990, Schedule H, Part V, Section B, 6c-6d]

As individual organizations begin to parse out the information from the 2015 Community Health Needs Assessment, it is Barton's hope and intention that this will foster greater desire to embark on a community-wide community health improvement planning process. Barton Health has expressed this intention to partnering organizations and is committed to being a productive member in this process as it evolves.

Barton Health
FY2015-FY2018 Implementation Strategy

Barton Health is proud to partner with you in your health and invite you to take part in making South Lake Tahoe a healthier place to live.

This summary outlines Barton Health's plan (Implementation Strategy) to address our community's health needs by 1) sustaining efforts operating within a targeted health priority area; 2) developing new programs and initiatives to address identified health needs; and 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Hospital-Level Community Benefit Planning

Priority Health Issues To Be Addressed

In consideration of the top health priorities identified through the CHNA process — and taking into account hospital resources and overall alignment with the hospital's mission, goals and strategic priorities — it was determined that Barton would focus on developing and/or supporting strategies and initiatives to improve the top three health issues identified:

- Mental Health & Mental Disorders
- Substance Abuse
- Access to Healthcare Services

Integration with Operational Planning [IRS Form 990, Schedule H, Part V, Section B, 6e]

Barton health has included Community Health as a main pillar within its strategic plan. In addition, annually a community benefit report will be produced and released to the public and stakeholders.

Priority Health Issues That Will Not Be Addressed & Why [IRS Form 990, Schedule H, Part V, Section B, 7]

In acknowledging the wide range of priority health issues that emerged from the CHNA process, Barton decided to focus on the top three health issues that the Steering Committee deemed the highest priority. While Barton may not directly work to resolve all health issues identified, Barton is committed to working collaboratively with our community partners whenever possible to help address health needs as they occur. In addition to focusing on the top three identified priorities, Barton has committed to address specific issues of each of the identified areas for improvement as described below.

Proposed Activities to Address Health Needs	
Cancer	*Ongoing cancer awareness and prevention services include: Cash pay lung cancer CT, lectures on cancer prevention (skin, breast, prostate and others), cancer wellness program, enhanced mammogram technology, ongoing wellness messages, and ongoing assessment to potentially increase oncology services and partnerships for those with a cancer diagnosis.*
Dementia, Including Alzheimer's Disease	*Barton is committed to maintaining resources for the Skilled Nursing Facility, Barton Psychiatry, and Home Health and Hospice to preserve current Alzheimer's services for the community.*
Heart Disease & Stroke	*Barton aims to maintain cardiology services, recruit a pulmonologist and expand sleep medicine, focusing on sleep apnea. Barton will continue to conduct heart health lectures, healthy heart campaigns, and an EKG cash pay program.*
Infant Health	*An educational campaign coordinated between Barton Women's Health and Barton's Family Birthing Center will highlight the importance of early prenatal care. There is a focus on the expansion and reorganization of childbirth classes to be more responsive to community health issues. Two examples include a first trimester education class and a new mom support group. Barton OBGYN's will conduct outreach to community organizations and the high school to discuss family planning.*
Injury & Violence	*To reduce recidivism for alcohol related trauma injuries, Barton Emergency is conducting a Brief Intervention Program. Barton will collaborate with anti-violence organizations such as CASA and Live Violence Free. Barton will conduct education on local risks, injury prevention lectures, safety and wellness ads, and collaboration on programs such as "Every 15 Minutes." Barton is also committed to providing on-site event medical coverage to triage and treat emerging medical issues that can be treated successfully with early intervention.*
Nutrition, Physical Activity & Weight	*Efforts to promote healthy nutrition and an active lifestyle include: We Can! in elementary schools, Human Health and Social Well-being Committee, Nutrition lectures, diabetes education, dietician access for both inpatient and outpatient, healthy choices in Barton Café, Bfit and employee wellness programs, collaboration with local gyms, kids' fitness camps, and other community collaborations.*
Oral Health	*Barton is committed to maintaining an active collaboration with First 5 initiatives and the dental van and will continue to support options to provide Denti-Cal coverage locally.*
Tobacco Use	*Barton remains committed to decreasing tobacco use within the community through smoking cessation classes, lung cancer CT scans, in-office posters about the dangers of smoking, periodic articles about the dangers of traditional and e-cigarette use, maintaining a non-smoking campus, and information through the health library.*

Implementation Strategies & Action Plans [IRS Form 990, Schedule H, Part V, Section B, 6f-6h]

The following displays outline Barton Health's plans to address the three priority health issues chosen for action in the FY2015-FY2018 period.

1. Mental Health	
Community Partners	Members of the South Lake Tahoe Mental Health Cooperative and the Community Health Advisory Committee
Goal	Improve the care flow system and create partnerships for service providers in the community to empower and strengthen the quality of life for South Lake Tahoe residents.
Timeframe	FY2015-FY2018
Scope	Strategy will focus on residents in the South Lake Tahoe basin.
Strategies and Objectives	**Strategy #1: Expand and maintain mental health services** • Hire third LCSW at Barton Community Health Center (CHC) to address mental health and medical needs for Medi-Cal patients. Coordinate counseling services and case management for CHC patients • Maintain tele-psychiatry program for patients through Barton physician offices • Maintain tele-psychiatry and evaluation program for in-patients regarding proper medication evaluation and recommendations prior to discharge • Maintain and expand adult services at Barton Psychiatry through two existing child psychiatrists and an additional adult psychiatrist. • Maintain hospice grief counseling and children's bereavement camp (Camp Sunrise) • Continue partnership with First Five program where Barton nurses visit new mothers post-partum to identify post-partum depression and offer resources • Internal mental health task force will ensure proper treatment and referral options for mental health patients throughout the system including the emergency department and inter-facility transfers **Strategy #2: Spearhead community collaboration and engagement to improve the mental health care flow system** • Provide resources to maintain a coordinator for the Mental Health Cooperative whose purpose is to improve the care flow system to empower and strength our community • Attend and facilitate regular meetings of the cooperative. Host an annual community-wide forum focused on addressing mental health

	needs in the area • Carry out recommended strategies and seek resources to support strategies of the cooperative **Strategy #3: Build awareness through education and prevention campaign** • Implement awareness campaign during Mental Health Awareness Month: poster series, articles, advertisement, web and social media awareness • Develop suicide prevention and awareness campaign • Distribute campaign materials to Barton Health medical practices, hospitals and other community partners • Incorporate mental health topics into the Wellness Lecture Series and other speaking engagements • Expansive mental health resources will be included in the community resource guide and updated annually • Community health grant resources will be reserved for services provided by local non-profit organizations to address unmet mental health needs in the community • Barton will explore options and feasibility of an online resource/website to include mental health and other community resources
Financial Commitment	$3.8 million
Anticipated Impact	A coordinated system network of providers to assist mental health patients at any point of entry into the system.
Evaluation of Impact	• Lower rates of suicide and attempted suicide as tracked by Barton Emergency Dept. • Reduction in delays in the emergency room for proper transfer of mental health patients as tracked by Barton Risk Management.
Results	Pending

2. Substance Abuse	
Community Partners	Members of the South Tahoe Drug Free Coalition
Goal	To reduce youth and adult substance use in the South Lake Tahoe region.
Timeframe	FY2015-FY2018
Scope	Strategy will focus on residents in the South Lake Tahoe basin.
Strategies and Objectives	**Strategy #1: Participate in the South Tahoe Drug Free Coalition** • Attend monthly meetings and other committee meetings as assigned • Contribute time, data and other resources to the coalition to further

	their mission and ensure successful program outcomes. Particular programs include: permanent drug take back bins, in-home lock boxes, an alternative suspension program at the middle and high schools, and educating parents on the dangers of alcohol and drug use for teenagers. • Support efforts on grant funding which may include data, matching funds, information sharing to the public, and other collaboration as identified **Strategy #2: Support community prevention programs** • Community health grant resources will be reserved for services provided by local non-profit organizations to address substance abuse within the community • Provide staff and financial support for community-wide initiatives such as the Drug Store Project, Every 15 Minutes and other local non-profit organizations • Be involved, and express opinions regarding the health of the community at public meetings **Strategy #3 Conduct outreach and education on the effects of alcohol and drug abuse** • Implement the Brief Intervention Program in the emergency department and explore options for expansion within the service line or at other facilities. • Implement awareness campaign annually through: poster series, articles, advertisement, web and social media awareness • Disseminate appropriate information to Barton staff and physicians and coordinate internal trainings as requested • Substance abuse resources will be included in the health resource guide updated annually **Strategy #4: Enhance internal protocols to reduce the abuse of prescription narcotics.** • Barton Health's internal Integrated Pain Management Group will work toward ensuring consistent and proper treatment and referral options for chronic pain patients. Protocols for evaluation and treatment for acute and chronic pain patients will be evaluated and amended. • Barton Health will research and introduce appropriate alternative therapies to patients throughout the Barton Health system including aromatherapy, integrative medicine, meditation, massage therapy and others. • Barton Health will contract with a Pain Management specialist to offer consultations and guidance to chronic pain patients as needed.
Financial Commitment	$1.2 million
Anticipated Impact	Capacity building through Barton Health and our main partner, the South Tahoe Drug Free Coalition with an emphasis on prescription drugs, alcohol and

	marijuana use. Local awareness and recognition of substance abuse problems within South Lake Tahoe region.
Evaluation of Impact	• Less alcohol and drug use reported in the 2018 CHNA survey and California Healthy Kids Survey. • Fewer visits from drug overdose reported in Barton's Emergency Dept. • System wide prescription narcotic protocols for Barton Health contracted physicians.
Results	Pending

3. Access to Healthcare Services	
Community Partners	Members of the Community Health Advisory Committee
Goal	To improve access to primary care and preventative medicine.
Timeframe	FY2015-FY2018
Scope	Strategy will focus on residents in the South Lake Tahoe basin.
Strategies and Objectives	**Strategy #1: Improve access to care at Barton Community Health Center** • Create streamlined operations to ease appointment setting, same-day appointments and phone contacts • Promote specialized services to the community to increase awareness and access for full range of services • Promote the health center to occupational workforce for temporary and seasonal employees that are under or uninsured • Promote Community Health Center as a Patient Centered Medical Home and advertise the benefits of such a model **Strategy #2: Increase insurance coverage for the community through outreach for Covered California and Medi-Cal** • Conduct outreach, training and enrollments regarding the Affordable Care Act, specifically Covered California and Medi-Cal • Train and maintain certification for Barton Health System and Barton Health employees to become certified enrollment counselors for Covered California • Act as a resource for the community to answer questions and enroll consumers into medical health coverage • Ensure website has information and access to inform consumers regarding health insurance options for the South Lake Tahoe region **Strategy #3: Expand depth of medical services for the community** • Explore feasibility of adding new services such as Pulmonology, Oncology, expanded OB/GYN services, Integrative Medicine and others

	as community needs arise • Continue wellness programs for improved access: Labs, EKG, CT Scans, MRI and explore others as need arises • Develop and implement the vision for a Center of Excellence, creating a holistic and centralized space for orthopedic & sports medicine promoting streamlined healing and wellness **Strategy 4: Improve care coordination between inpatient, outpatient and specialty medical services** • Create centralized medical campus within the regulations of the City of South Lake Tahoe's Tahoe Valley Area Plan • Advertise MyChart and other valuable patient care tools as they become available to encourage empowered access for patients in their health care • Improve primary care access and assignment for the community to facilitate regular check-ups and increase usage of preventative medicine
Financial Commitment	$15 million
Anticipated Impact	More community members have Primary Care Providers and practice ongoing, preventative medicine to increase wellness in the community. Increased holistic view of care through Center of Excellence, Integrative Medicine and Patient Centered Medical Home Model.
Evaluation of Impact	• Reduction in unnecessary Emergency Dept. visits • Increase in Barton patients with assigned Primary Care Providers • Certification for Community Health Center as Patient Centered Medical Home
Results	Pending

Adoption of Implementation Strategy

[IRS Form 990, Schedule H, Part V, Section B, 6a-6b]

On September 24, 2015, the Board of Barton Memorial Hospital, which includes representatives from throughout the South Lake Tahoe region, met to review this plan for addressing the community health priorities identified through our Community Health Needs Assessment. The Board approved this Implementation Strategy and the related budget items to undertake these measures to meet the health needs of the community.

Board Approval & Adoption:

_____ Name & Title

_____ Date