



**Community Health Needs Assessment
Implementation and Action Plan for
Fiscal Years 2012-2015**

Adopted by Barton Health's Board of Directors on November 2, 2012

Barton Health

2012 Community Health Needs Assessment

In the spring of 2012, 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 from South Lake Tahoe Region from Tahoma, CA on the West Shore to Glenbrook, NV on the East. In addition to the hospital, Barton Health (Barton) manages an additional 19 physician offices and clinic practices. With nearly 1,000 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 dedicates us to the delivery of safe, high quality health care to community members and visitors. We are committed to compassionate, personalized, comprehensive and responsive treatment of all of our patients and other guests.

Our expanded vision will elevate us to new heights in the delivery of healthcare by committing resources to sustain our critical presence in our community. Our patients will have a predictable, measurable, positive experience that exceeds their expectations. We are committed to integrity, collaboration and excellence through the practice of our four Service Standards: Safety, Respect, Image, and Efficiency.

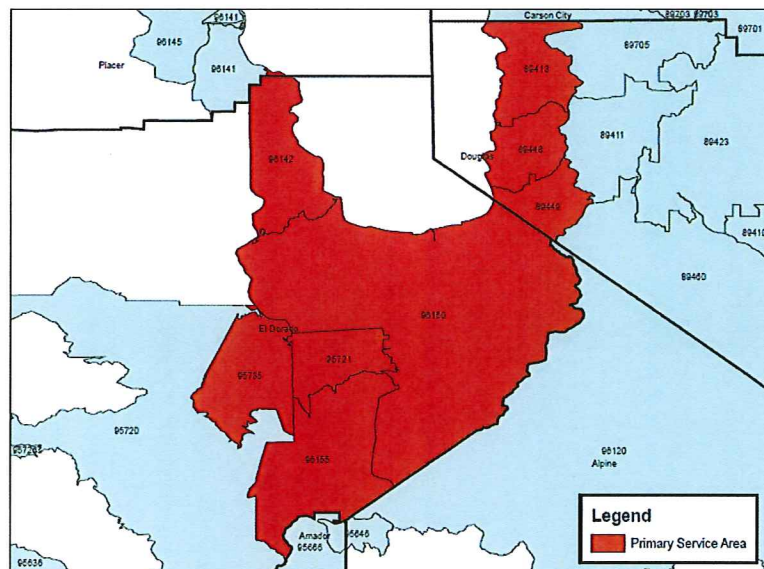
Definition of the Community Served

[IRS Form 990, Schedule H, Part V, Section B, 1a.](#)

Barton Health completed its last Community Health Needs Assessment in spring 2012.

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: 95375, 95721, 95735, 96150, 96155, 96156, 96158, 89413, 89448 and 89449. A geographic description is illustrated in the following map. This community definition was determined because >80% of Barton's patients originate from this area.

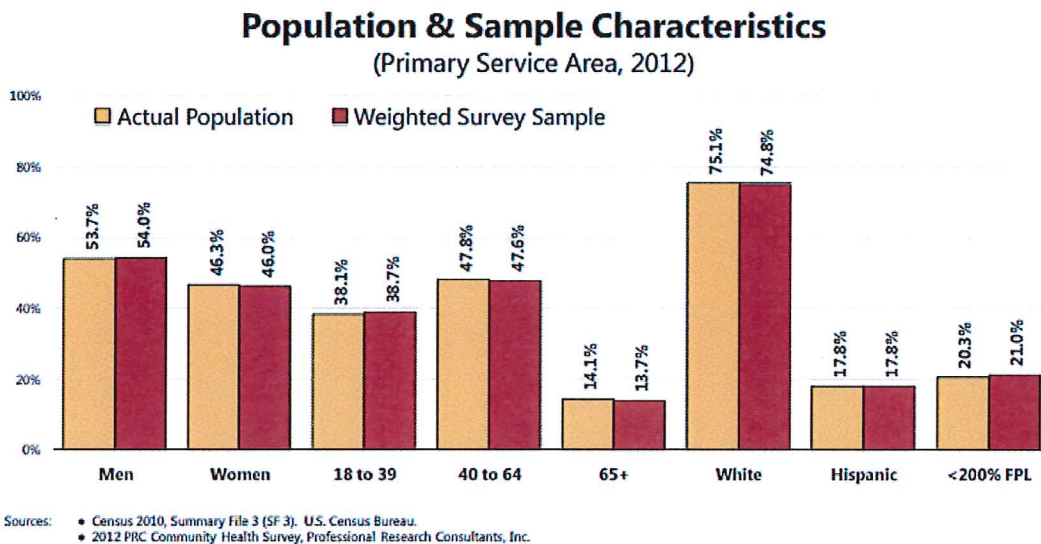


Demographics of the Community

[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. And, 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 are 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.]



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.

Existing Healthcare Facilities & Resources

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

Barton Memorial Hospital and our physician offices are available to respond to the health needs of our residents through the following resources:

Barton Audiology
Barton Case Management Services
Barton Community Clinic
Barton Ear, Nose and Throat
Barton Family Medicine
Barton General Surgery
Barton Internal Medicine
Barton Pediatrics
Barton Psychiatry
Barton Rehabilitation and Sports Medicine
Barton Rheumatology
Barton Skilled Nursing Facility
Emergency Department
Family Birthing Center
Gastrointestinal (G.I.) Lab
Home Health and Hospice
Laboratory Services
Medical Imaging
Nutrition Services
Occupational Health
Ski Clinics: Heavenly Mountain Resort and Sierra-at-Tahoe
Stateline Urgent Care and Family Practice
Tahoe Orthopedics and Sports Medicine

We also recognize the other available health resources available to the community and actively participate in many collaborative groups such as the Lake Tahoe Collaborative, the Community Advisory Committee, and the South Tahoe Drug Free Coalition in addition to others, to stay abreast of the various resources available to South Lake Tahoe residents. Some of those resources include (not an inclusive list):

Mental Health Services and Facilities:

El Dorado County Health and Human Services-Mental Health Division, Tahoe Youth and Family Services, Live Violence Free, A Balanced Life, NAMI, Tahoe Turning Point

Nursing Home/Adult Care:

City of South Lake Tahoe Senior Center, Elder Options, OPEN, A Hand at Home, Adult Protective Services, Cancer League

Other Community Resources Include:

El Dorado County Health and Human Services, Vitality, Family Resource Center, Alta Regional, El Dorado County Victim Witness Program, CASA, Child Protective Services, Boys and Girls Club, Christmas Cheer, Choices for Children, Lake Tahoe Unified School District, Lake Tahoe Community College

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 Advisory Steering Committee with members from the Community Advisory Committee. This project received input and guidance from 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 a series of Key Informant Focus Groups. Qualitative data input includes primary research gathered through a series of Key Informant Focus Groups.

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. These secondary data are only available at the county level; to best match the Primary Service Area, data from El Dorado County in California and Douglas County in Nevada were used. These were obtained from the following sources (specific citations are included with the graphs throughout this report):

- Centers for Disease Control & Prevention
- National Center for Health Statistics
- California Department of Public Health
- Nevada Department of Health and Human Services, Nevada State Health Division
- California Uniform Crime Report
- Crime in Nevada
- US Census Bureau
- US Department of Health and Human Services
- US Department of Justice, Federal Bureau of Investigation

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]

As part of the community health assessment there were two focus groups held on March 29, 2012 with members of the Barton Health Community Health Needs Assessment Advisory Steering Committee. One group was primarily clinicians and medical professionals, and the other was with key informants from community based organizations. In all, 21 individuals took part in these focus groups, including physicians, other health professionals, public health officials, social service providers and other community leaders.

A list of recommended participants for the focus groups was provided by Barton Health with input from members of the Advisory Steering Committee. 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. Participants included a representative of public health, as well as several individuals who work with low-income, minority or other medically underserved populations, and those who work with persons with chronic disease conditions.

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.

Areas of Opportunity for Community Health Improvement

The following "health priorities" represent recommended areas of intervention, based on the information gathered through this Community Health Needs Assessment and the guidelines set forth in *Healthy People 2020*. From these data, opportunities for health improvement exist in the region with regard to the following health areas.

Access to Health Services	<ul style="list-style-type: none"> • Lack of Health Insurance Coverage • Insurance Instability • Cost of Physician Visits • Routine Checkups [Adults] (Including Screening for Blood Pressure/Cholesterol) • Lack of Dental Insurance Coverage • Routine Eye Exams • Ratings of Local Healthcare
Cancer	<ul style="list-style-type: none"> • Cancer Deaths (Prostate Cancer, Lung Cancer)
Dementias, Including Alzheimer's Disease	<ul style="list-style-type: none"> • Alzheimer's Disease Deaths
Housing	<ul style="list-style-type: none"> • Displacement • Exposure to Mold, Radon, Lead
Immunization & Infectious Diseases	<ul style="list-style-type: none"> • Seasonal Flu Shots (65+)
Injury & Violence Prevention	<ul style="list-style-type: none"> • Unintentional Injury Deaths (Poisonings/Accidental Overdoses, Motor Vehicle Crashes, Falls) • Family Violence (Domestic Violence, Child Abuse)
Mental Health & Mental Disorders	<ul style="list-style-type: none"> • Suicides
Substance Abuse	<ul style="list-style-type: none"> • Cirrhosis/Liver Disease Deaths • High-Risk Alcohol Use • Drug-Induced Deaths • Illicit Drug Use
Tobacco Use	<ul style="list-style-type: none"> • Cigarette Smoking • Chronic Lower Respiratory Disease (CLRD) Deaths

Prioritization Process

[IRS Form 990, Schedule H, Part V, Section B, 1g, 6g]

After reviewing the Community Health Needs Assessment findings, the CHNA Steering Committee met on Friday, July 27, 2012, to determine the health needs to be prioritized for action in FY2012-FY2015.

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 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.

Prioritization Results

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

1. **Substance Abuse** (45%)
2. **Access to Healthcare Services** (23%)
3. **Mental Health** (19%)
4. **Dementia including Alzheimer's disease** (6%)
5. **Unintentional Injury and Violence** (5%)
6. **Immunization and Infectious Disease** (2%)
7. **Cancer** (did not receive enough votes for percentage)
8. **Tobacco Use** (did not receive enough votes for percentage)
9. **Housing** (did not receive enough votes for percentage)

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 2012 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

FY2012-FY2015 Implementation Strategy

Barton Health is proud to be Lake Tahoe's healthcare provider for the past fifty years. We look forward to partnering 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:

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

Integration with Operational Planning

[IRS Form 990, Schedule H, Part V, Section B, 6e]

Beginning in 2013, Barton will include a Community Benefit section within its strategic and operational plan.

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, we are 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 a fraction of each of the identified areas for improvement as described below.

Health Issues Not Chosen as Priority	Response to Issue
Dementia including Alzheimer's disease	<i>While this is not one of the top 3 priority areas for expansion and action, Barton is committed to maintaining resources for our Skilled Nursing Facility, Barton Psychiatry, and Home Health and Hospice to preserve our current Alzheimer's services for our community. Dr. Sullivan, Neurologist, will continue to evaluate patients and case management will continue to research viable resources for this segment of our health patients.</i>
Unintentional Injury and Violence	<i>Although not a main focus, Barton will conduct community outreach campaigns around unintentional injuries through our summer safety campaigns and wellness lecture series. Other community based organizations such as Live Violence Free are more suited to address family violence issues within our community, and Barton will continue to refer to them and support their efforts. Barton will continue to work with local ski resorts to train and educate ski patrol and staff on "on mountain" safety measures for employees and skiers/boarders. Barton will continue to prepare wellness lectures, editorials and other material that educate the public on accident prevention.</i>
Immunization & Infectious Diseases	<i>Barton Health will not only maintain, but develop internal protocols and update our internal flu vaccination policy for all employees. Better suited to address this issue in the community as a whole is the El Dorado County Health and Human Services (Public Health Division) and we look forward to collaborative and supportive efforts with them. Barton continues to support flu vaccinations for all ages by providing community flu clinics at cost to adults and free to children 3-18 years of age.</i>
Cancer	<i>Barton will continue to create awareness surrounding cancers affecting our region and will make attempts to highlight areas of concern through our wellness lecture series: breast cancer, prostate cancer and lung cancer. We also will be creating community awareness about the correlation between radon and lung cancer and work on collaborative community groups such as EmPower El Dorado.</i>
Tobacco	<i>Barton Health has limited resources to address alcohol, tobacco and other drug issues. However certain initiatives will allow Barton to participate in tobacco prevention and education strategies with our community.</i>
Housing	<i>Because housing is not a service traditionally provided by a community hospital, this is not a need that will be addressed directly from Barton Health. However, we are committed to participating and supporting community collaboratives that will be addressing this issue for the South Lake Tahoe area. For environmental housing concerns, Barton is cooperative with the City of South Lake Tahoe's Lead Safe Program and EmPower El Dorado's advocacy program.</i>

The following displays outline Barton Health’s plans to address the three priority health issues chosen for action in the FY2012-FY2015 period.

1. ACCESS TO HEALTH SERVICES	
Community Partners	Community Advisory Committee Members: Melinda Choy – Acupuncture; Wendy David – LTUSD and First Five; Claire Fortier – City of SLT; Les Marsh – Vail Resorts; Margaret McKean – LTUSD Nurse; Amanda Morozumi – CASA; Judy Cefalu – Barton Auxiliary; Dr. Jean Makris; Dr. Dan Norman; Dr. Liz Muckerman; Angela Moore – Barton Foundation Trustee; Alissa Nourse – TYFS; Josefina Solano and Hector Reyes – EDC Health and Human Services; Dena Schwarte – Barton Board of Directors; Delicia Spees – Family Resource Center; Tere Tibbetts – LTCC; Brian Uhler – SLT Police and Fire; Michael Ward - Consultant
Goal	To improve access to healthcare services by organizing community resources, improving communication’s amongst existing providers and expansion of the only subsidized community clinic.
Outcome Measures	Community residents report easier access to community health services.
Timeframe	FY2012-FY2015
Scope	Strategy will focus on residents in the South Lake Tahoe basin.
Strategies & Objectives	<p>Strategy #1: Expand Barton Community Clinic</p> <ul style="list-style-type: none"> • Increase physical space. • Create streamlined operations to ease appointment setting. • Promote specialized services to community. • Promote clinic to occupational workforce for temporary and seasonal employees that are under or uninsured. • Promote clinic as medical home; promote reduced costs options and services available. <p>Strategy #2: Create health resource guide for the community.</p> <ul style="list-style-type: none"> • Develop community resource guide with basic information. • Distribute guide to community members and healthcare providers. • Update resource guide annually to ensure up to date information and services within the service area. <p>Strategy #3: Enhance existing communication and services for seniors.</p> <ul style="list-style-type: none"> • Through CAC, coordinate service meetings to identify and narrow service gaps for seniors. • Create plan to address barriers such as transportation. • Continue to discuss and develop home health model

	Strategy #4: Expand Telehealth Program <ul style="list-style-type: none"> • Increase the number specialties provided through the telehealth program. • Expand telehealth program for underinsured and uninsured patients at the Community Clinic including psychiatry.
Financial Commitment	\$2,325,500
Anticipated Outcomes	<ul style="list-style-type: none"> • Resource Guide • Increased visits to community clinic • Transportation policy for seniors
Results	Pending

2. MENTAL HEALTH & MENTAL DISORDERS	
Community Partners	<ul style="list-style-type: none"> • El Dorado County Mental Health • Lake Tahoe Collaborative • Community Based Organizations Offering Counseling Services • NAMI
Goal	Increase access to mental health services.
Outcome Measures	Fewer patients will report barriers to accessing mental health services.
Timeframe	FY2012-FY2015
Scope	Strategy will focus on residents in the South Lake Tahoe basin.
Strategies & Objectives	Strategy #1: Expand and maintain mental health services <ul style="list-style-type: none"> • Hire child psychiatrist at Barton Psychiatry to address mental health and medical needs for younger patients. • Expand telehealth psychiatry program for uninsured or underinsured patients at the Community Clinic. • Maintain tele-psychiatry program for in-patient medication evaluation and recommendations prior to discharge. • 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.

	<p>Strategy #2: Connect partners with funding resources</p> <ul style="list-style-type: none"> • Collaborate when feasible on funding and grant applications to support community partners. • Work with Community Advisory Committee to assist in identifying community resources available. • Identify opportunities for transitional mental health population from hospital <p>Strategy #3: Community Education and Prevention</p> <ul style="list-style-type: none"> • Support and disseminate El Dorado County's Suicide Prevention Information • Patients with mental health issues are seen by social worker for evaluation and referrals. • Incorporate mental health topics into the Wellness Lecture Series • Attend and participate in monthly Lake Tahoe Collaborative meetings • Incorporate community health information on website and print media to educate on mental health issues.
Financial Commitment	\$792,000
Anticipated Outcomes	<ul style="list-style-type: none"> • Increased patient visits to Barton Psychiatry through office or telehealth. • Decreased wait time in community to see a psychiatrist. • Hundreds of residents will receive suicide prevention information • Annually provide community outreach and education surrounding mental health topics
Results	Pending

3. SUBSTANCE ABUSE	
Community Partners	South Tahoe Drug Free Coalition and Its Member Organizations
Goal	Reduce substance abuse within the community.
Outcome Measures	Less use of substances reported on 2015 Community Health Needs Assessment.
Timeframe	FY2012-FY2015
Scope	Strategy will focus on residents in the South Lake Tahoe basin.

<p>Strategies & Objectives</p>	<p>Strategy #1: Participate in the South Tahoe Drug Free Coalition</p> <ul style="list-style-type: none"> • Attend monthly meetings and other committee meetings as assigned. • Contribute time, data and other resources to the coalition to further their mission. • Support efforts on grant funding which may include data, matching funds, information sharing to the public, and other collaboration as identified. <p>Strategy #2: Support community prevention programs</p> <ul style="list-style-type: none"> • Support the Drug Store Project. • Support Every 15 Minutes Project. • Contribute funding and staff time to help with these and other community initiatives. • Be involved, and express opinions regarding the health of our community at public meetings <p>Strategy #3: Identify resources for patients with alcohol and drug dependency.</p> <ul style="list-style-type: none"> • Social work will be involved in finding and providing resources for patients. • Implement poster campaign to create awareness on substance use and encourage patients to seek help. • Disseminate information to Barton staff and physicians and coordinate internal trainings. • Substance abuse resources will be included in the health resource guide. <p>Strategy #4: Enhance internal protocols to reduce the abuse of prescription narcotics.</p> <ul style="list-style-type: none"> • Implement EPIC at all Barton facilities and offices. This widespread electronic records system curtails patients from office hopping to get increased amounts of controlled substances. • Tahoe Carson Valley Medical Group will review the physician policy on controlled substances.
<p>Financial Commitment</p>	<p>\$434,000</p>
<p>Anticipated Outcomes</p>	<ul style="list-style-type: none"> • Less alcohol and drug use in 2015 survey. • Capacity building through Drug Free Coalition. • Fewer deaths from drug use. • Fewer ED visits from drug overdose.
<p>Results</p>	<p>Pending</p>

Adoption of Implementation Strategy

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

On November 2, 2012, 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:



By Name & Title

11/2/12

Date