



**Community Health Needs Assessment
Implementation and Action Plan**

Adopted by Barton Health's Board of Directors on November 15, 2018

Barton Health

2018 Community Health Needs Assessment

In the winter of 2018, 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 more than 15 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 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

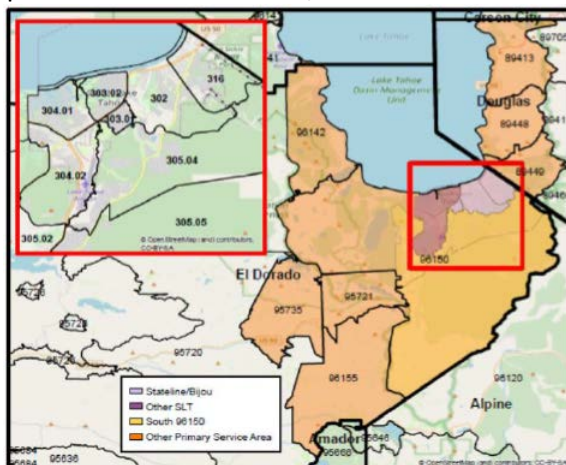
[\[IRS Form 990, Schedule H, Part V, Section B, 1a\]](#)

Barton Health completed its last Community Health Needs Assessment in spring 2015. Comparative results are available.

CHNA Community Definition

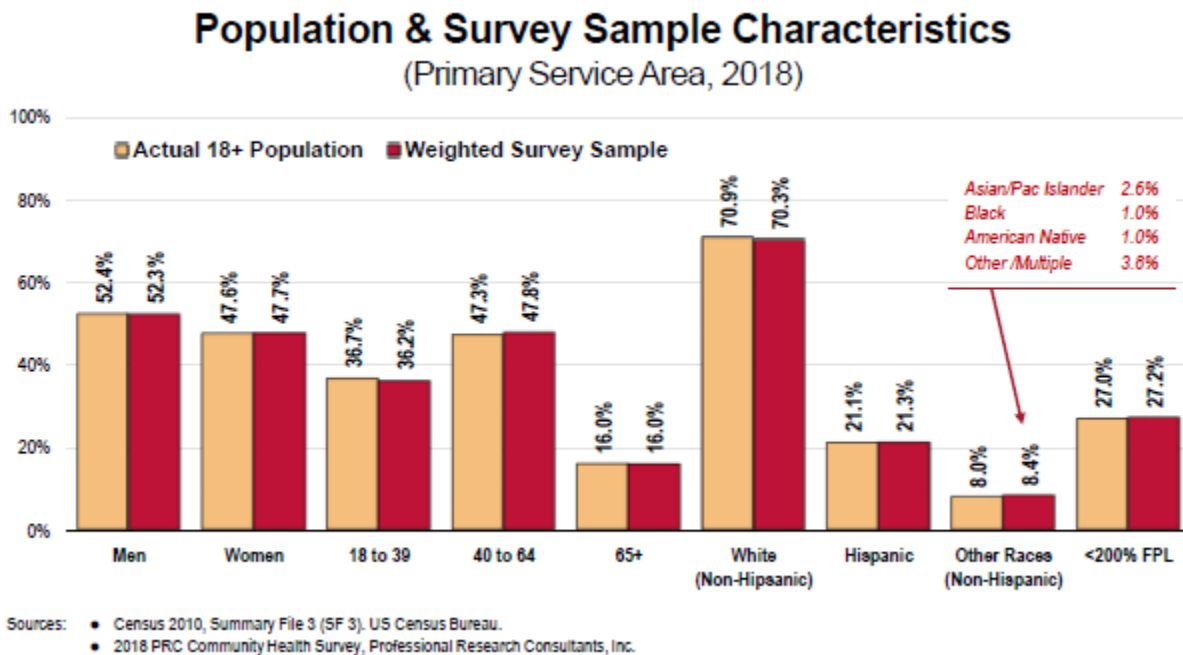
The study area for the survey effort is defined as each of the residential ZIP Codes comprising the Primary Service Area of Barton Health, including 95721, 95735, 96142, 96150, 96151, 96155, 96156, 96158, 89413, 89448, and 89449. This community definition, determined based on the ZIP Codes of residence of recent patients of Barton Health, is illustrated in the following map.

In reporting, results are further segmented to census tracts associated with the Stateline/Bijou area of South Lake Tahoe, the rest of the City of South Lake Tahoe, as well as the county that falls within 96150, and Other Primary Service Area, including Zephyr Cove and Homewood. This community definition, determined based on the ZIP Codes of residence of recent patients of Barton Health, is illustrated in the following map.



To accurately represent the population studied, Professional Research Consultants (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 are gathered, respondents are examined by key demographic characteristics (namely sex, 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 chart outlines 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 2018 guidelines place the poverty threshold for a family of four at \$25,100 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 (<200% of) the poverty threshold; “**mid/high income**” refers to those households living on incomes which are twice or more (≥200% of) 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 + El Dorado Community Hub Program
Lake Tahoe Collaborative
Local Dentists
Medi-Cal
NAMI
Nonprofit Organizations
Private Insurance Brokers
Schools
Sierra Child and Family Services
South Lake Tahoe Cancer League
Tahoe Magic
Tahoe Transportation District
Urgent Care

Arthritis, Osteoporosis & Chronic Back Conditions

Acupuncturist
Barton Community Health Center
Barton Center for Orthopedics & Wellness

Cancer

Barton Home Health and Hospice
Barton Memorial Hospital
Barton Infusion Center
Carson Tahoe Cancer Center
Dr. Semrad
Dr. Perez
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 Sr Center

Diabetes

Barton Community Health Center
Barton Health
Barton Memorial Hospital
Local Doctors

Urgent Care
Weight Watchers

Family Planning

Barton Community Health Center
Barton Women's Health
Local Doctors
El Dorado County Public Health Department
Mount Tallac School
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
Barton Family Medicine
Barton Primary Care
Local Pharmacies
El Dorado County Public Health Nurse

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
Level III Trauma 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
Sierra Child & Family Services

*Suicide Prevention Network
Tahoe Magic, Salvation Army, Section 8
Tahoe Turning Point
Tahoe Youth and Family Services
Telehealth Access
Psychiatric Facilities*

Nutrition, Physical Activity & Weight

*Barton Performance by ALTIS
Boys and Girls Club
Christmas Cheer
Center for Orthopedics & Wellness CHIP Program
Family Resource Center
First 5
Lake Tahoe Bicycle Coalition
Lake Tahoe Community College
LTUSD
Mediterranean Diet Class
Mind over Weight Matters Class
Police Activity League
Private Gyms
Private Yoga Studios
SLT Recreation Center
UC Davis Nutrition Programs
Weight Watchers*

Oral Health

*Barton Community Health Clinic
Community-Minded Dentists
Dr. Mireya Ortega
Dr. April Westfall
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
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
EDC Health Department
Keep Tahoe Blue
NA/AA*

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 from these sources throughout the process.

CHNA Goals & Objectives

This Community Health Needs Assessment, a follow-up to similar studies conducted in 2012 and 2015, is a systematic, data-driven approach to determining the health status, behaviors and needs of residents in the Primary Service Area of Barton Health. 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 that historically have 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 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 Primary Service Area were obtained from the following sources (specific citations are included with the graphs throughout this report):

- California Department of Public Health, Center for Health Statistics and Informatics, Public Health Policy and Research Branch
- 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 stratified random sample of 400 individuals age 18 and older in the Primary Service Area, separated into four sub-communities of interest to Barton Health. 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 PRC.

For statistical purposes, the maximum rate of error associated with a sample size of 400 respondents is $\pm 4.9\%$ at the 95 percent confidence level.

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 also was 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, 81 community stakeholders took part in the Online Key Informant Survey, as outlined below:

Online Key Informant Survey Participation		
Key Informant Type	Number Invited	Number Participating
Physicians	28	10
Public Health Representatives	6	6
Other Health Providers	22	17
Social Services Providers	26	12
Other Community Leaders	44	36

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.

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.

After reviewing the Community Health Needs Assessment findings, the Community Health Advisory Committee met on August 16, 2018 to determine the health needs to be prioritized for action. During the detailed presentation of the CHNA findings, consultants from PRC used audience response system (ARS) technologies to lead 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	<ul style="list-style-type: none"> ● “Fair/Poor” Mental Health ● Stress Over Mortgage/Rent ● Suicide Deaths ● <i>Mental Health ranked as top concern in the Online Key Informant Survey</i>
2. Substance Abuse	<ul style="list-style-type: none"> ● Cirrhosis/Liver Disease Deaths ● Current Drinking ● Excessive Drinking ● Unintentional Drug-Related Deaths ● Use Marijuana/Hashish ● Negatively Affected by Substance Abuse (Self or Other’s) ● <i>Substance Abuse ranked as a top concern in the Online Key Informant Survey</i>
3. Access to Healthcare Services	<ul style="list-style-type: none"> ● Barriers to Access <ul style="list-style-type: none"> ○ Appointment Availability ○ Finding a Physician ● Primary Care Physician Ratio ● Routine Medical Care (Adults) ● Routine Medical Care (Children) ● Eye Exams ● Ratings of Local Healthcare
4. Infant Health & Family	<ul style="list-style-type: none"> ● Prenatal Care

Planning	
5. Nutrition, Physical Activity & Weight	<ul style="list-style-type: none"> • Fruit/Vegetable Consumption • Low Food Access • Obesity [Adults] • Medical Advice on Weight • Leisure-Time Physical Activity
6. Immunization & Infectious Disease	<ul style="list-style-type: none"> • Flu Vaccination [Age 65+] • Pneumonia Vaccination [High-Risk Age 18-64]
7. Heart Disease & Stroke	<ul style="list-style-type: none"> • Cardiovascular disease is a leading cause of death • High Blood Pressure Management • Blood Cholesterol Screening • Overall Cardiovascular Risk
8. Injury & Violence	<ul style="list-style-type: none"> • Falls [Age 45+] • Violent Crime Experience • Domestic Violence Experience
9. Cancer	<ul style="list-style-type: none"> • Cancer is a leading cause of death • Female Breast Cancer Screening [Age 50-74] • Colorectal Cancer Screening [Age 50-75]
10. Tobacco Use	<ul style="list-style-type: none"> • Cigarette Smoking Prevalence
11. Potentially Disabling Conditions	<ul style="list-style-type: none"> • Activity Limitations • Caregiver

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 2018 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

FY2018-FY2021 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 organization resources and overall alignment with the hospital’s mission, goals and strategic priorities — it was determined that Barton would continue 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 Community Health Advisory 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

Infant Health & Family Planning

An educational campaign coordinated between Barton Women’s Health and Barton’s Family Birthing Center will highlight the importance of early prenatal care. We will continue to offer childbirth classes to be responsive to community health issues. Barton OBGYN’s will conduct outreach through wellness lectures and include midwife and doula education so as to include community members considering a home birth. Post-partum home visits will continue for new moms. We will also explore plans to be recognized as a Baby Friendly Hospital which implements policies and care practices that meet the gold standard for mother/baby care practices related to breastfeeding.

Nutrition, Physical Activity & Weight

Efforts to promote healthy nutrition and an active lifestyle include: We Can! and Harvest of the Month in elementary schools, Nutrition lectures, diabetes education, dietician access for both inpatient and outpatient, diabetes educator in the Wound Care Clinic, healthy choices in Barton Café, BHealthy Hub Program for employees with the possibility of extending this program to local employers, collaboration with local gyms, kids’ fitness camps, and other community collaborations. The new Center for Orthopedics & Wellness will provide classes and education on the CHIP program and Mediterranean Diet. Continued sponsorship of local youth events.

Immunization & infectious Disease

Barton will continue to collaborate with the Infectious Disease Department in collaboration with the Public Health Department and schools on communication about outbreaks. A physician screening process includes high risk diseases. Hospital campaigns include hand washing, mask and flu season education. A pediatric immunization reminder letter will be sent out as part of our commitment to PCMH. A free vaccination program is available through our Community Health Center. We also partner and promote Back to School immunizations with County Public Health.

Heart Disease & Stroke

Barton aims to maintain cardiology services, maintain our pulmonologist and maintain sleep medicine education, focusing on sleep apnea. Barton will continue to conduct heart health lectures, healthy heart campaigns, and offer free wellness lab draws. The PCMH Program will include efforts to control blood pressure including an Anthem Outreach Program.

Injury & Violence

To reduce recidivism for alcohol related trauma injuries, Barton Emergency is conducting a Brief Intervention Program along with alcohol screening. 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. Last, we are committed to continuing the Stop the Bleed program to help educate and prepare community members (including first responders, teachers and

	<i>students) for a mass casualty event. New screening for abuse will be incorporated into annual wellness visits.</i>
Cancer	<i>Ongoing cancer awareness and prevention services include: lectures on cancer prevention (skin, breast, prostate and others), cancer wellness program, enhanced mammogram technology, ongoing wellness messages, radon education, and ongoing assessment to potentially increase oncology services and partnerships for those with a cancer diagnosis including telemedicine and a partnership with UC Davis and Gene Upshaw Cancer Center. Barton will increase outreach for recommended screenings. A new fundraising effort, Pink Heavenly, will raise awareness and benefit cancer patients.</i>
Tobacco Use	<i>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, vaping and e-cigarette use, maintaining a non-smoking campus, and information through the health library.</i>
Potentially Disabling Conditions	<i>Through our Home, Health & Hospice & Palliative Care programs, we provide support groups for caregivers. We also participate in local health fairs for our senior population.</i>

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 FY2018-FY2021 period.

1. Mental Health	
Community Partners	Members of the South Lake Tahoe Mental Health Cooperative and the Community Health Advisory Committee.
Goal	Improve the referral and care flow system and create partnerships for service providers in the community to empower and strengthen the quality of life for South Shore residents.
Timeframe	FY2018-FY2021
Scope	Strategy will focus on residents in the South Shore.
Strategies and Objectives	<p>Strategy #1: Spearhead community collaboration and engagement to improve the mental health care flow system</p> <ul style="list-style-type: none"> • Through a recently awarded federal grant create a technological platform that supports and strengthens an integrated system of medical and behavioral healthcare by streamlining referrals amongst community partners • Provide resources to maintain a Coordinator for the Behavioral

	<p>Health Network (BHN) of South Lake Tahoe, whose purpose is to improve the care flow system to empower and strength our community</p> <ul style="list-style-type: none"> • Attend and facilitate regular meetings of BHN. Host a community-wide forum focused on addressing mental health needs in the area • Recommended strategies and seek resources to support strategies of BHN • Barton’s internal mental health task force will coordinate proper treatment and referral options for mental health patients throughout the system including the emergency department and inter-facility transfers <p>Strategy #2: Continue to provide mental health services</p> <ul style="list-style-type: none"> • Barton Health to participate in community technological platform for an improved referral system • Improve depression screening rates at annual wellness visits • Employ three licensed clinical social workers to address behavioral health and medical needs for patients. Coordinate counseling services and case management for primary care patients at primary care physicians and Barton Community Health Center locations • Provide tele-psychiatry services for patients through Barton physician offices • Offer adult psychiatry 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 Barton nurses visit new mothers post-partum to identify post-partum depression and offer resources through support groups <p>Strategy #3: Build awareness through education and prevention campaign</p> <ul style="list-style-type: none"> • Implement awareness campaign during Mental Health Awareness Month: poster series, articles, advertisement, web and social media awareness • Conduct a suicide prevention and awareness campaign and support Suicide Prevention Network’s efforts • 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 <p>Comprehensive mental health resources will be included in the community resource guide and updated annually</p> <ul style="list-style-type: none"> • Community health grant resources will be allocated to services provided by local non-profit organizations to address unmet mental health needs in the community
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Anticipated Impact	Reduce stigma and improve access and coordinated care for patients.
Evaluation of Impact	<ul style="list-style-type: none"> Track data to support successful behavioral health referrals Identify the barriers with delays in the emergency room for proper transfer of mental health patients. Implement depression screening through annual wellness visits and/or establishing a Barton primary care physician.

2. Substance Abuse	
Community Partners	Members of the former South Tahoe Drug Free Coalition
Goal	To reduce youth and adult substance use in the South Lake Tahoe region
Timeframe	FY2018-FY2021
Scope	Strategy will focus on residents in the South Shore community.
Strategies and Objectives	<p>Strategy #1: Enhance internal protocols to reduce prescribing of narcotics and implement Medication Assisted Treatment program.</p> <ul style="list-style-type: none"> Implement the Medication Assisted Treatment program through the Community Health Center and any supporting programs that help reduce opioid overdose Barton Health, through the Center for Orthopedics & Wellness, 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 <p>Strategy #2: Participate in the coordinated groups around substance abuse, including the Hub & Spoke effort, the Opioid Coalition and the former Drug Free Coalition</p> <ul style="list-style-type: none"> Attend community meetings as appropriate Contribute time, data and other resources to further the mission of prevention and education and ensure successful program outcomes. Particular programs may include: permanent drug take back bins, in-home lock bags, 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,

	<p>matching funds, information sharing to the public, and other collaboration as identified</p> <p>Strategy #3: Support community prevention programs</p> <ul style="list-style-type: none"> • 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, Athlete Committed and other local non-profit organizations • Be involved, and express opinions regarding the health of the community at public meetings <p>Strategy #4: Conduct outreach and education on the effects of alcohol and drug abuse</p> <ul style="list-style-type: none"> • 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
Anticipated Impact	Build an effective Medication Assisted Treatment program that supports patients who have opioid addiction. Local awareness and recognition of substance abuse problems within South Shore community.
Evaluation of Impact	<ul style="list-style-type: none"> • Track visits from drug overdose as reported in Barton’s Emergency Dept. • Established Medication Assisted Program with tracked number of patients on Subuxone • System wide prescription narcotic protocols for Barton Health physicians

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	FY2018-FY2021
Scope	Strategy will focus on residents in the South Lake Tahoe basin.

Strategies and Objectives	<p>Strategy #1: Improve access and care coordination through meeting criteria for the Patient Centered Medical Home (PCMH) designation</p> <ul style="list-style-type: none"> • Create streamlined operations to ease appointment setting, same-day appointments and appointment reminders • Monitor access needs and preferences of primary care patients; including third next available appointment measure, CG-CAHPS survey measures; and other sources such as monitoring complaints related to access. • Increase the number of patients seen for preventative care (immunizations, screenings, annual wellness visits, etc.) <p>Strategy #2: Increase insurance coverage for the community through outreach for Covered California and Medi-Cal</p> <ul style="list-style-type: none"> • 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 <p>Strategy #3: Expand additional or enhanced medical services for the community</p> <ul style="list-style-type: none"> • Explore feasibility of adding or expanding services such as outpatient wound care clinic, expanded OB/GYN services, Gastroenterology, expanded telemedicine services such as tele-perinatology and tele-nephrology, and others as community needs arise • Continue wellness programs for improved access: Labs, EKG, CT Scans, MRI and explore others as need arises • Support the new wellness service line in the Center for Orthopedics & Wellness through education and marketing <p>Strategy #4: Create and implement an outreach plan for the Latino Community</p> <ul style="list-style-type: none"> • Work with community partners such as Family Resource Center, school districts, Lake Tahoe Community College, El Dorado County Community Hub, El Dorado County Substance Use Disorder and UC Cal Fresh to coordinate ideas and plans to best reach and educate this community. • Explore hosting and/or participating in community gathering events that best reach and serve our Latino community. • Regularly participate in cafecitos.
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Anticipated Impact	Allowing patients to receive care they need in a clear and timely manner leading to improved health.
Evaluation of Impact	<ul style="list-style-type: none"> • Increased number of patients with assigned Barton Primary Care Providers • Increased same-day appointment availability • Increase in patients attending annual wellness visits

Adoption of Implementation Strategy [\[IRS Form 990, Schedule H, Part V, Section B, 6a-6b\]](#)

On November 15, 2018, 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