Tahoe Forest Hospital District

Community Health Improvement Plan

September 27, 2011

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TABLE OF CONTENTS

EXECUTIVE SUMMARY	4
TAHOE FOREST HOSPITAL DISTRICT	7
TFHD AREA SERVED	9
TFHD ASSETS & STRENGTHS	10
HEALTH PRIORITIES & GOALS:	12
Access to Primary Care	13
Immunizations	16
Ethnic Disparities	19
Mental Health	21
Substance Abuse	24
GAP SURVEY	27
ADDITIONAL HEALTH CONSIDERATIONS	30
THE PATH AHEAD	31
COMMUNITY PARTNERS	32
RESEARCH CONSIDERATIONS	33
REFERENCES	34

EXECUTIVE SUMMARY

In December of 2010, Tahoe Forest Health System initiated a comprehensive community health needs assessment at the direction of the Hospital District Board of Directors. The purpose of the assessment was to gather current statistics and feedback on the key health issues facing full-time residents living within the hospital district. Tahoe Forest Health System contracted with Holleran, a Lancaster, Pennsylvania-based research firm with expertise in health assessments, to execute the various research components.

Key area agencies, social service representatives and staff were engaged in the process through the establishment of a Steering Committee. This Committee was instrumental in editing and finalizing the survey instrument and analysis of the results. Their constructive engagement in the assessment, and in the development of this plan, cannot be overstated.

The community health needs assessment included a Secondary Data Profile as well as a Household Survey across 473 households in the district. The residents included in the survey reflected the demographic makeup of the district by age, gender, race and ethnicity. Information from a secondary data profile detailed the district's demographic trends, mortality and morbidity rates, and other quality of life measures. The survey of area residents collected data regarding preventive screenings, risky behaviors, and lifestyle characteristics.

At a public workshop held on May 16, 2011, Hospital District Board Members, area health care professionals, social service agencies, public health representatives, and other local organizations examined the resulting data. These individuals participated in a strategic planning process and prioritization exercise, which resulted in five strategic issues identified as health priorities. The issues were selected based on the seriousness of the issue, as well as on the ability for the community to make an impact at improving the condition.

It was the Board's direction at this workshop to create a community health improvement plan (CHIP) to begin to address the five issues, which follow in no particular order:

- ***Access to Primary Care/Medical Home***
- ***Immunizations (Adult & Child)***
- ***Ethnic Disparities***
- ***Mental Health***
- ***Substance Abuse***

Detail on each of these issues begins on page 12 of this document.

The overarching goal of the CHIP is to engage community members to address together the root causes of disease and illness, leading to greater illness prevention and healthy lifestyle choices. The focus will be on education, prevention and well-care. Creating working groups from within and throughout our community to identify and implement solutions will ensure the highest likelihood of success.

During the needs assessment cycle, two other groups associated with Tahoe Forest Health System also formed to address community health: The North Tahoe Community Health Initiative, focused on creating a rural prototype for being an Accountable Care Organization[i]; and the Medical Steering Committee of the Center for Health and Sports Performance, whose objectives include prevention and wellness programming for the community. It is the desire of the Health System to bring these groups, plus the region's health agencies, together to create collaborative and comprehensive solutions to improve our community's health status.

This document suggests a path forward to begin the program design phase to address the identified health issues. Specific strategies and metrics to meet the objectives will be developed and carried out by teams to include Health System representatives, the physician community, and our regional partners.

After the Board has received, modified and accepted this report, the next step in the process is a collaborative action cycle during which the strategies deemed most promising will be implemented. The CHIP process is aimed at

facilitating community engagement to achieve an optimal and equitable level of health among all residents living within the Tahoe Forest Hospital District and the Incline Village community of Nevada. Interested medical providers, agencies, residents and community groups are encouraged to join the CHIP process as it enters the program development phase.

For more information, please call Maia Schneider at 530 582 6313, email mschneider@tfhd.com or visit the Tahoe Forest Health System website, www.tfhd.com.

ABOUT TAHOE FOREST HOSPITAL DISTRICT

Tahoe Forest Hospital, originally opened in 1952, is a 25-bed, full-service, not-for-profit health care facility. It serves a wide range of patients: full-time and part-time residents of the Truckee and North Lake Tahoe area, and tourists and travelers from around the world. The hospital provides its patients with highly personalized care, state-of-the-art medical technology and a knowledgeable professional staff. The hospital is governed by a five-member Board of Directors elected by voters of the Tahoe Forest Hospital District[ii].

In 1996, Tahoe Forest Hospital District purchased what is now the Incline Village Community Hospital on the North Shore of Lake Tahoe. Originally opened in 1981, the Incline Village facility was built with community philanthropy and changed ownership several times prior to being acquired by Tahoe Forest Hospital District. The District subsequently replaced outdated technology, upgraded existing services, and now maintains this facility.

In 2006, the Tahoe Forest Cancer Center opened its doors. The mission of the Cancer Center is to provide the highest quality cancer treatment and care to its patients using the most appropriate and current cancer therapies available in an honest, supportive, compassionate and respectful manner.

It was during this same time that the District evolved its strategic planning into that of a "System" offering a variety of medical services and programs to the community in addition to the two hospitals. Although Tahoe Forest Hospital District remains a public California Special District, the Health System model is used for planning and programming purposes. The District and System are one and the same.

In 2007, the voters of the Tahoe Forest Hospital District voted overwhelmingly in support of Measure C, a general obligation bond to pay for projects to update and upgrade the Tahoe Forest Hospital campus. Included in those projects are a new Cancer Center building; expansion and

upgrades to the Emergency Department and Skilled Nursing Facility; and a new South Building to replace the older portions of the campus that currently house the Women and Family Center.

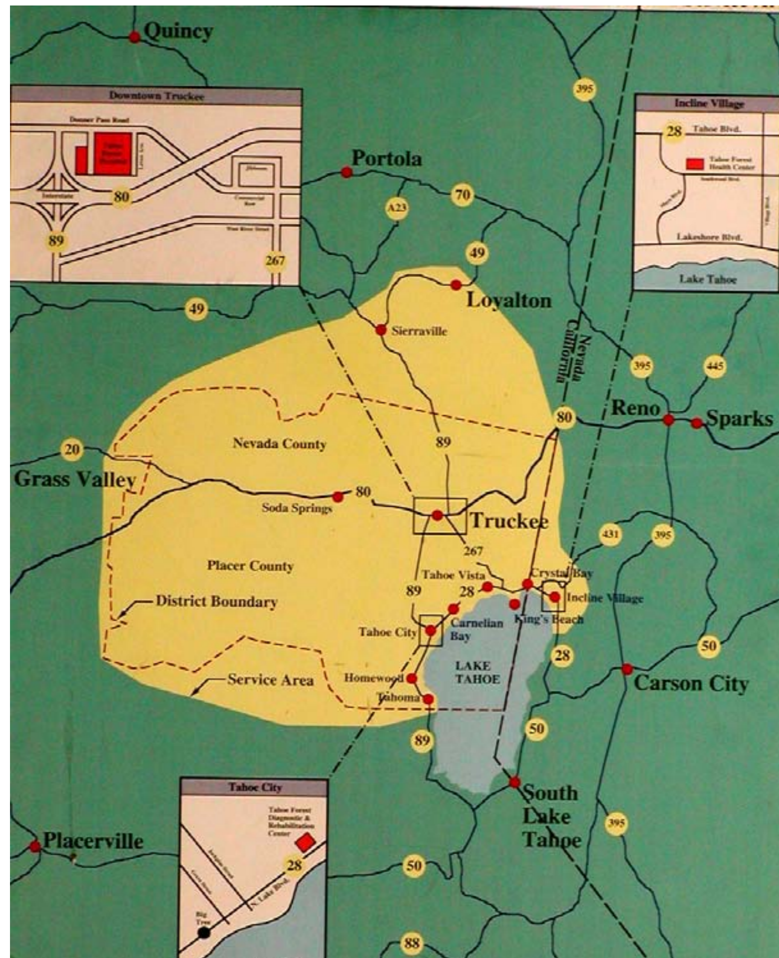
The Health System's medical and support services currently include:

- Cancer Center
- Cardiac/Pulmonary Rehab
- Diagnostic Imaging
- Emergency Room
- Health Clinic
- Occupational Health and Wellness
- Home Health Services
- Hospice Services
- Intensive Care Unit
- Laboratory
- Skilled Nursing Facility
- Medical Surgical Unit
- MultiSpecialty Clinic
- Pastoral Care Program
- Physical Therapy & Rehabilitation Services
- Respiratory Therapy Services
- Retail Pharmacy
- Sleep Disorder Center
- Support Programs and Groups
- Surgical Services
- Tahoe Center for Health & Sports Performance
- Wellness Education and Sports & Fitness Class Calendar
- Women & Family Center

TFHD AREA SERVED

The Tahoe Forest Hospital District boundary and secondary service area are illustrated below. The District boundaries are shown as a dashed line and the secondary service area is included in the yellow zone. The needs assessment referenced in this plan surveyed residents from within the District (dashed line), plus Incline Village, Nevada.

The full-time population of our District is approximately 43,000. However, the Health System serves a much larger geographic area extending to 3,500 square miles and covering 5 counties.



COMMUNITY HEALTH ASSETS & STRENGTHS

In an attempt to take a global view of the community - its strengths as well as areas of opportunity- it is important to recognize the community assets and strengths that were identified through the assessment. Many communities take a strengths-based approach to addressing areas needing improvement. This method allows a community to fully understand its assets and develop ways to utilize those strengths to improve overall health and well-being.

The following points outline some of the positive findings identified through the assessment. "Positive" is defined as areas where the community statistics are more favorable than comparable regional, state, and national statistics. It should be noted that the list is not fully inclusive of all quality-of-life and health issues, but reflects the most prominent statistics and feedback outlined in the report.

- **Single-mother households:** The percentage of single-mother households in the hospital district is below national figures and fewer children are being raised by mothers alone.

- **Poverty:** While similar to peer communities, the number of individuals and families that are living in poverty (7.4%) is below the national percentage (12.4%). Given the recent economic challenges, however, it is anticipated that the actual poverty statistics may be slightly above the reported 7.4%.

- **Education:** The number of individuals in the area with a high school diploma or college degree is above the national number.

- **Teen pregnancy:** The number of births to mothers under the age of 20 is 4% lower than the national average.

- **Birth weights:** Roughly 96% of the births in the Hospital District are of "normal" weight. Incline Village birth weights are equitable to national averages.

- **Sexually transmitted diseases:** Communicable diseases, particularly sexually transmitted diseases, are less prominent throughout the area than what is seen nationally.

- **General health:** Approximately 32% of area residents perceive their overall health to be "Excellent." Nationally, 21% of respondents say their health is "Excellent."

- **High blood pressure:** Approximately two out of ten residents reported high blood pressure, which is 9% lower than elevated blood pressure rates nationally.

- **Cigarette smoking:** Fewer local individuals have smoked at least 100 cigarettes in their lifetime compared to nationally.

- **Physical activity:** Roughly 93% of individuals in the area engage in some form of moderate physical exercise in a typical week. That is 8% higher than the physical activity rates nationally.

HEALTH PRIORITIES & GOALS

The five prioritized community health issues are detailed in the following section. When the Hospital District Board of Directors identified these goals they recognized that these are not inclusive of all health issues in the community (see also "Additional Health Considerations" on page 30 of this document). However, the five issues included in this document were rated as being among the most serious of community issues and also those where the greatest impact can be made. The goal of any CHIP prioritization is to differentiate between the "vital few" and "important many."

With the pending implementation of a new Health Information Exchange (HIE), we anticipate a far improved ability to gather health data from local physicians, other health care providers, and Health System records. The goals within this plan identify some of the data collection points we can utilize to track goal attainment. We will be relying heavily on this data to measure our success and identify needed refinements as new programs are developed and implemented, and existing programs refined.

In the following pages, our needs assessment research findings related to each prioritized issue are detailed with graphs and narratives, and followed by the Board's goal statement. The purpose of the goal statement is to establish a vision for moving the community forward on that health issue. Potential measureable data points are also listed for each issue, which will allow involved agencies, organizations, and providers to evaluate progress toward the stated goal.

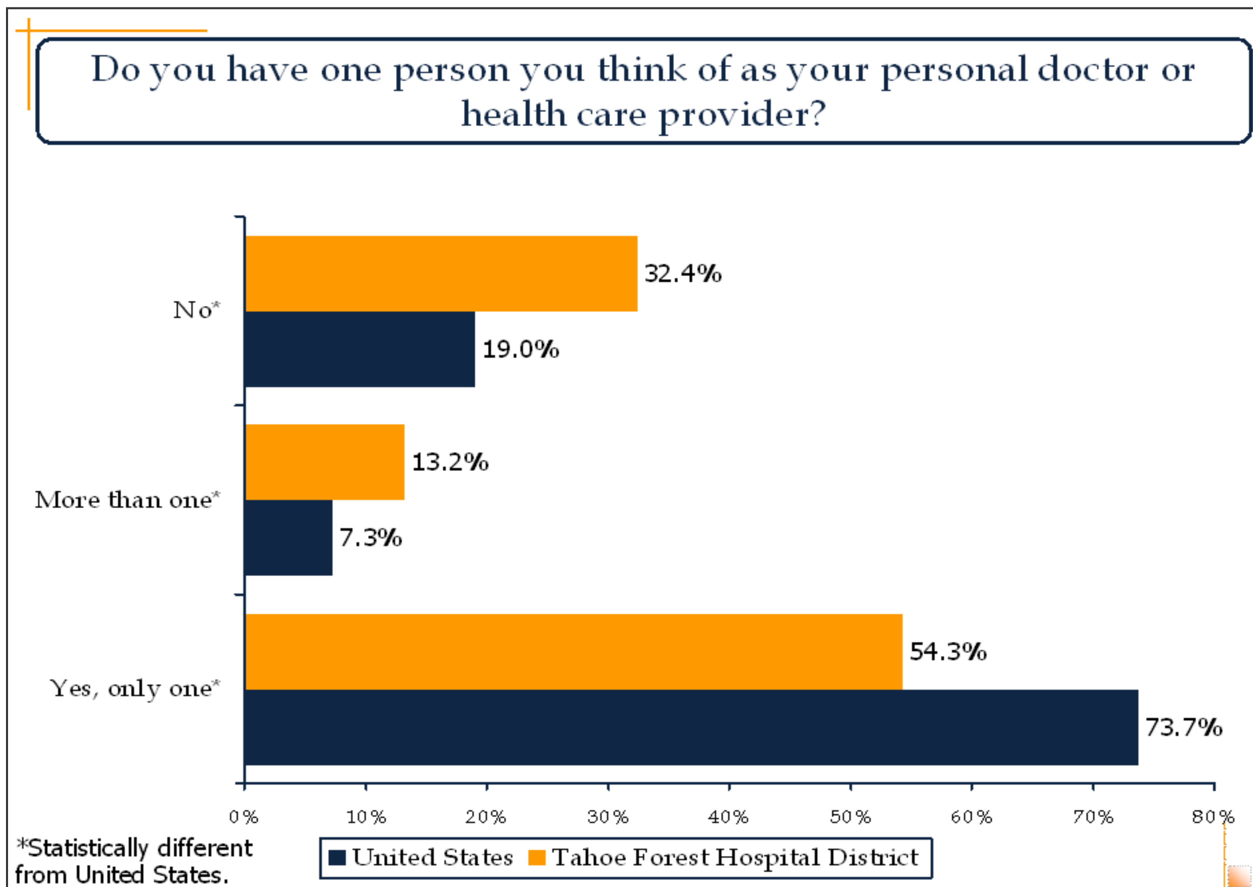
The Hospital District plans to undertake another formal needs assessment in 2014. The objectives to meet the goals identified in the following pages will be reviewed on an ongoing basis, and goal attainment will be measured against the data from the second assessment in three years.

It is important to note that the five key health issues are organized within this chapter in no particular order of importance.

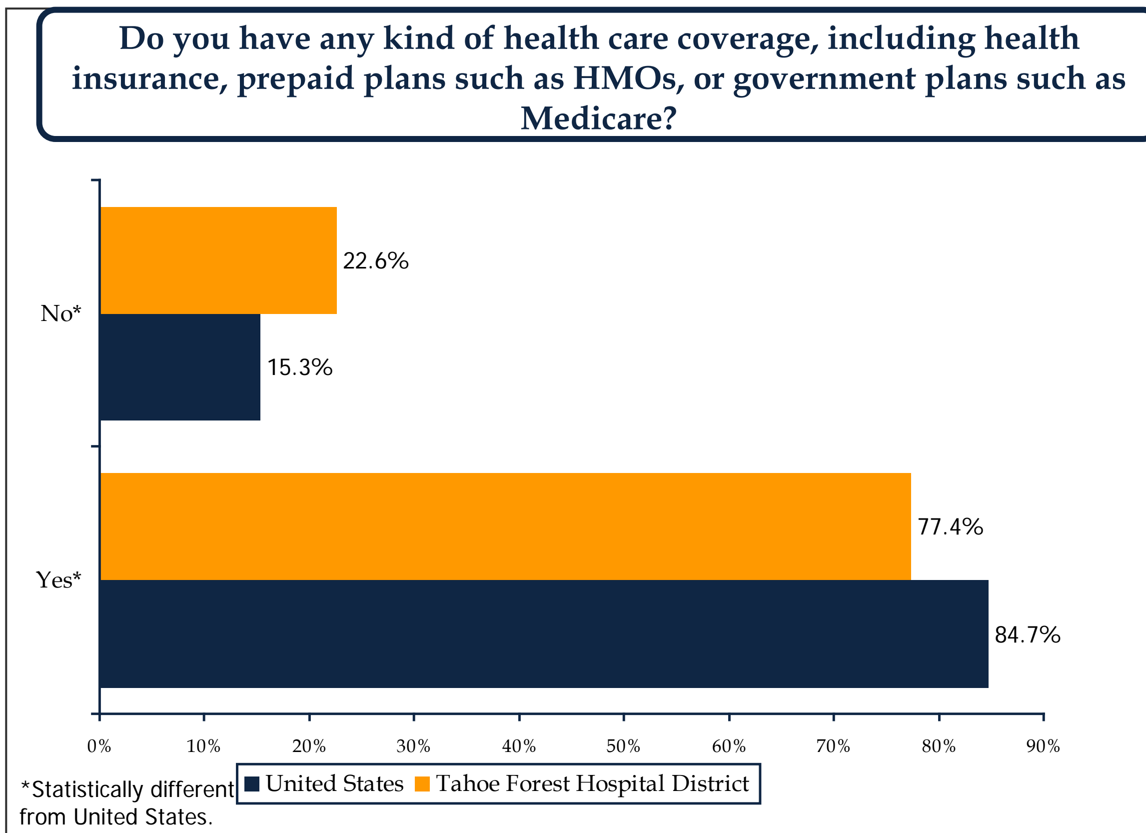
Issue: Access to Primary Care

One of the key focal points of Healthy People 2020[iii] is "Access to Health Services." As pointed out in the Healthy People 2020 document, ***"People with a usual source of care have better health outcomes and fewer disparities and costs."*** It is widely known in the medical community that having a usual primary care provider can increase the likelihood that patients receive comprehensive, high-quality care.

The Tahoe Forest Health System community health needs assessment revealed that only one-half of area adults (54.3%) have one individual they think of as their personal doctor or healthcare provider. This compares to nearly 74% nationally.



Despite lower poverty rates in the region, the assessment revealed that residents in the area were less likely to have health insurance (22.6% reporting no coverage) compared to nationally (15.3% reporting no coverage). There is a clear connection between healthcare coverage and an individual's likelihood of having an ongoing primary care provider. Among area adults who reported having health insurance, 64% have one person they think of as their personal doctor or healthcare provider. This figure drops to 19% among the uninsured.



In an effort to improve health outcomes through the promotion of a medical home for the residents of the community, Tahoe Forest Hospital District has elected to have this issue be one of its key areas of focus for the Community Health Improvement Plan.

OUR GOAL: *"All residents will be able to identify and access a primary care provider (medical home)."*

Objective:
By November 1, 2011, form a working group to include primary care physicians, health services agencies and staff to develop objectives and strategies to meet this goal.

Examples of objectives this group may consider include:

- Increase by 10% to 64% the number of residents in our community who can identify their medical home by June 1, 2014
- 100% of local primary care physicians will understand how to establish a primary care relationship with their patients by June 1, 2014 as evidenced by survey
- Identify and define models for "medical home" in addition to primary care physician practices and conduct community education

Potential data elements to collect and trend:

- Percentage of chronically ill local patients seen in ER or clinic without an identified primary care physician;
- Number of unique patient visits to primary care providers in each year
- Repeat of Community Health Needs Assessment every 3 years

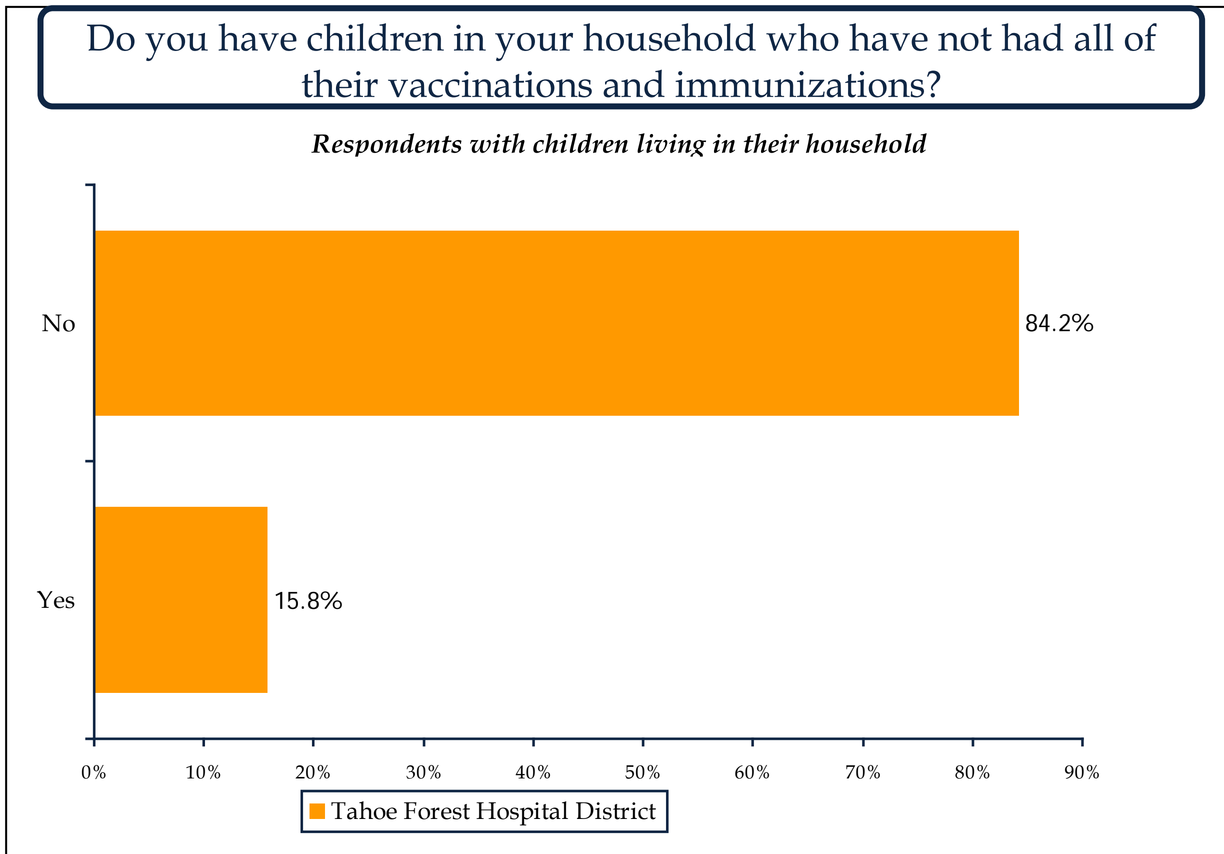
Issue: Immunizations

According to the World Health Organization (WHO)[iv], immunizations are a proven tool for controlling and even eradicating infectious diseases. While U.S. vaccination efforts have reduced many vaccine-preventable illnesses, these diseases still exist and can be passed on to people who are not protected by vaccines. Vaccine-preventable diseases have many social and economic costs: sick children miss school and can cause parents to lose time from work. These diseases also result in doctor's visits, hospitalizations, and even premature deaths.

Our assessment revealed that fewer area adults have had a flu shot in the previous year and fewer reported having had a pneumonia vaccination compared to adults nationally. It is also noteworthy to mention that female residents in the area are more likely to have had these immunizations than males.

According to a report from the California Department of Health, 65% of kindergarten students in the Tahoe Forest Hospital District entered school in 2010 with up-to-date immunizations. An additional 27% were given "conditional status" and 7% were noted as citing a personal belief exemption from the immunizations. While the definition of "up-to-date" can be debated, this suggests that there are a number of children that are not receiving the recommended suite of vaccinations.

Kindergarten Immunization Status	School Enrollment	Up-To-Date	Conditional	PBE
CUSD and Private Schools in Carmel	214	82.2%	7.9%	11.7%
TTUSD	**397**	**65.2%**	**27.0%**	**7.1%**
Donner Trail Elementary	12	100.0%	0.0%	0.0%
Glenshire Elementary	98	74.0%	21.0%	4.0%
Kings Beach Elementary	83	69.0%	24.0%	7.0%
Sierra Expeditionary Learning	10	90.0%	10.0%	0.0%
Tahoe Lake Elementary	63	57.0%	37.0%	6.0%
Truckee Elementary	131	55.0%	32.0%	11.0%



Of those families in our community who have children in their household who are not up to date on their vaccinations, 5% cited religious belief; 12% expressed concern for safety; 13% cited cost or lack of insurance as a barrier; and 70% stated "other."

OUR GOAL: *"We will improve immunizations among those receptive to them and aim to reduce vaccine preventable diseases."*

Objective:
By November 1, 2011, form a working group to include primary care physicians, education and preschool representatives, health services agencies and staff to develop and implement objectives and strategies to meet this goal.

Examples of objectives this group may consider include:

- All primary care providers in our District to be registered in the California Immunization Registry (CaIR) by June 1, 2014.
- Reduce the number of children on "immunization conditional status" in the region's schools by 20% by June 1, 2014
- Increase adult flu vaccinations by 6% by June 1, 2014

Potential data elements to collect and trend:

- Percentage of patients seen with current flu vaccine
- Percentage of patients seen with current pneumococcal vaccine
- Incidence of influenza compared to state averages
- Number of positive pneumococcal cultures
- Percentage of children with up-to-date vaccinations

Issue: Ethnic Disparities

The assessment revealed significant disparities and inequities between the health of Hispanic/Latino and non-Hispanic/Latino residents within the district's service area. Across many health indicators measured in the assessment, the Hispanic/Latino respondents reported poorer health outcomes, increased barriers to care, and more risky health behaviors than their Non-Hispanic counterparts.

The W. K. Kellogg Foundation funded a study through the Joint Center Health Policy Institute to examine the economic impact of health inequalities in the United States. The study uncovered that more than 30% of direct medical costs faced by African Americans, Hispanics, and Asian Americans were excess costs due to health inequities, accounting for more than $20 billion over a four-year period[v].

The following tables outline a sample of the Hispanic versus Non-Hispanic disparities uncovered in the recent health needs assessment among area residents.

	Hispanic	**Non-Hispanic**
"Excellent" general health	4.4%	40.8%
Percentage with some form of healthcare coverage	35.5%	91.5%
Occasion when needed to see a doctor, but could not because of cost	38.4%	10%
Never visited a doctor for a routine checkup	4.8%	0%
Obese (per BMI)	27.1%	10.5%

OUR GOAL: *"In our community, there should be no inequities in health with regard to ethnicity."*

Objective #1:
Form a community and physician-based working group by November 1, 2011 to research ethnic disparities, identify priorities and objectives to reduce or eliminate disparities, and agree on metrics and timelines for those objectives. This group should be representative of the community's demographic profile.

Examples of objectives this group may consider include:

- Reduce the percentage of Hispanic residents who needed to see a physician, but couldn't due to cost, by 10% by June 1, 2014
- Reduce obesity incidence in the Hispanic population by 5% by June 1, 2014
- Increase the number of Hispanic residents that have had a blood test for diabetes or high blood sugar in the past three years by 10% by June 1, 2014

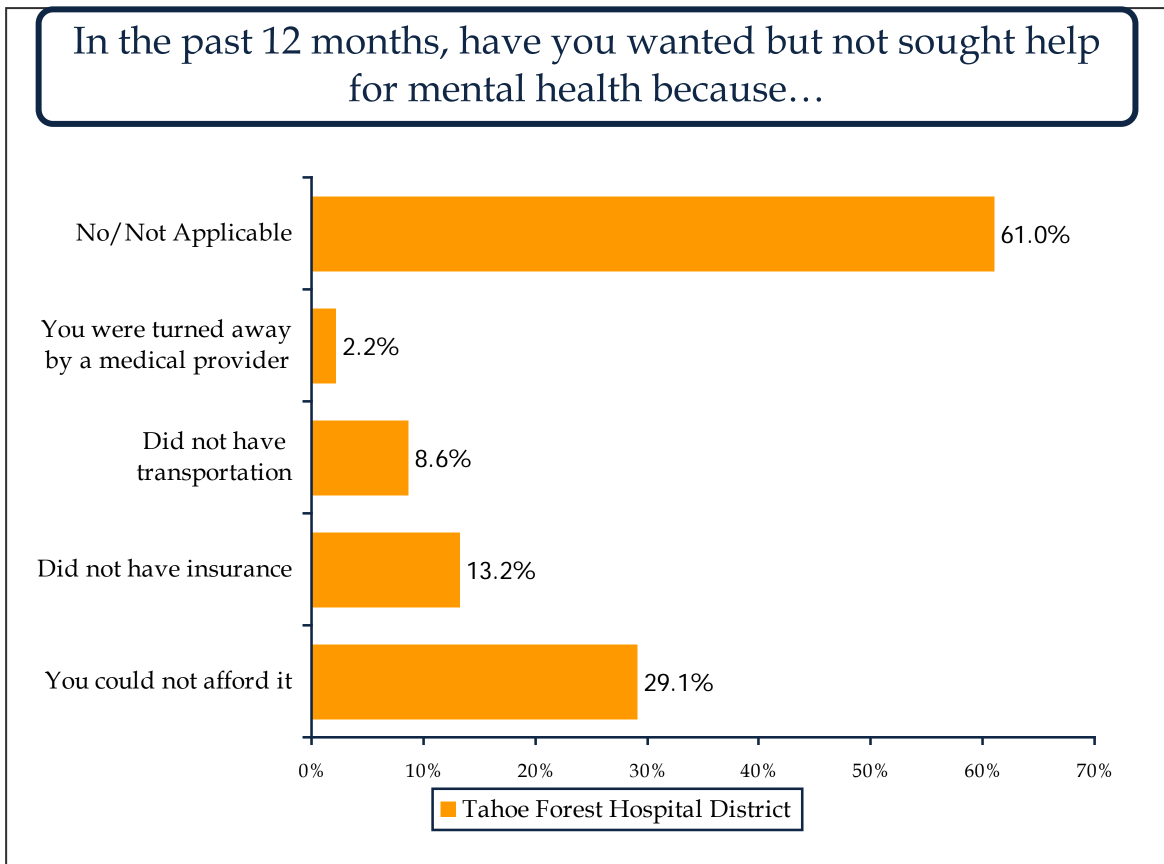
Potential data elements to collect and trend:

- Time since patient's last routine checkup
- Time since patient's last test for diabetes
- Time since patient's last cholesterol check
- Percentage of smokers, obese, depressives, hypertensives and hyperlipidemics, and % of each with interventions
- Time since patient's last colorectal and mammographic exam
- Adult vaccination rates

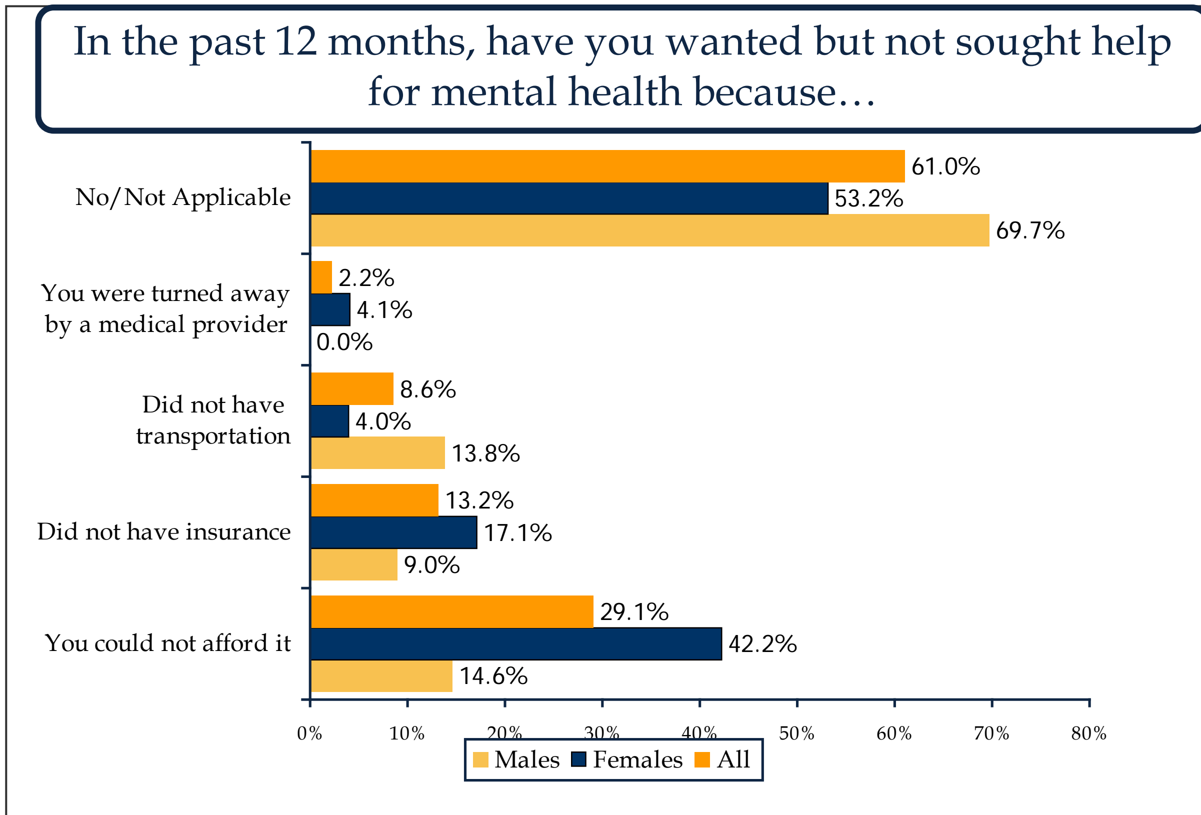
Issue: Mental Health

Sustaining good mental health in our community is a priority for all ages. When asked if they seriously considered attempting suicide in the previous 12 months, 13% of 9th graders and 11% of 11th graders responded affirmatively. It is important to note that these statistics are fairly equitable to the national percentages.

When area adults were asked if there was a time in the previous year that they wanted to seek mental health treatment, but did not, four out of ten adults responded in the affirmative. Roughly 29% of area adults are not able to afford mental health treatment, 13% lack insurance coverage for mental health services, nearly 9% do not have transportation to access treatment, and around 2% have been turned away by a medical provider. The graph below details these findings.



A few noteworthy trends are also important to note. Specifically, the females living in the district were more likely to have cost as a barrier compared to males (42.2% versus 14.6%). The reverse was true for transportation as a barrier to mental health treatment, with only 4% of females having transportation barriers compared to nearly 14% of men in the district. Here is the same graph as above, broken out by gender:



A number of studies have also shown that individuals with a mental illness are also more likely to use drugs, have poorer health outcomes, and have a shorter life expectancy than those without mental health issues.[vi]

OUR GOAL: *"Our residents will enjoy good mental health and those in need will have access to prevention and treatment."*

Objective #1: Convene a working group of physicians, health agency representatives and mental health providers by November 1, 2011 to identify priorities and programs and agree on metrics and timelines for those objectives.

Objectives this group may consider could be derived from examples in the document: "Rural Behavioral Health Programs and Promising Practices" published in June, 2011 by the U. S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, such as:

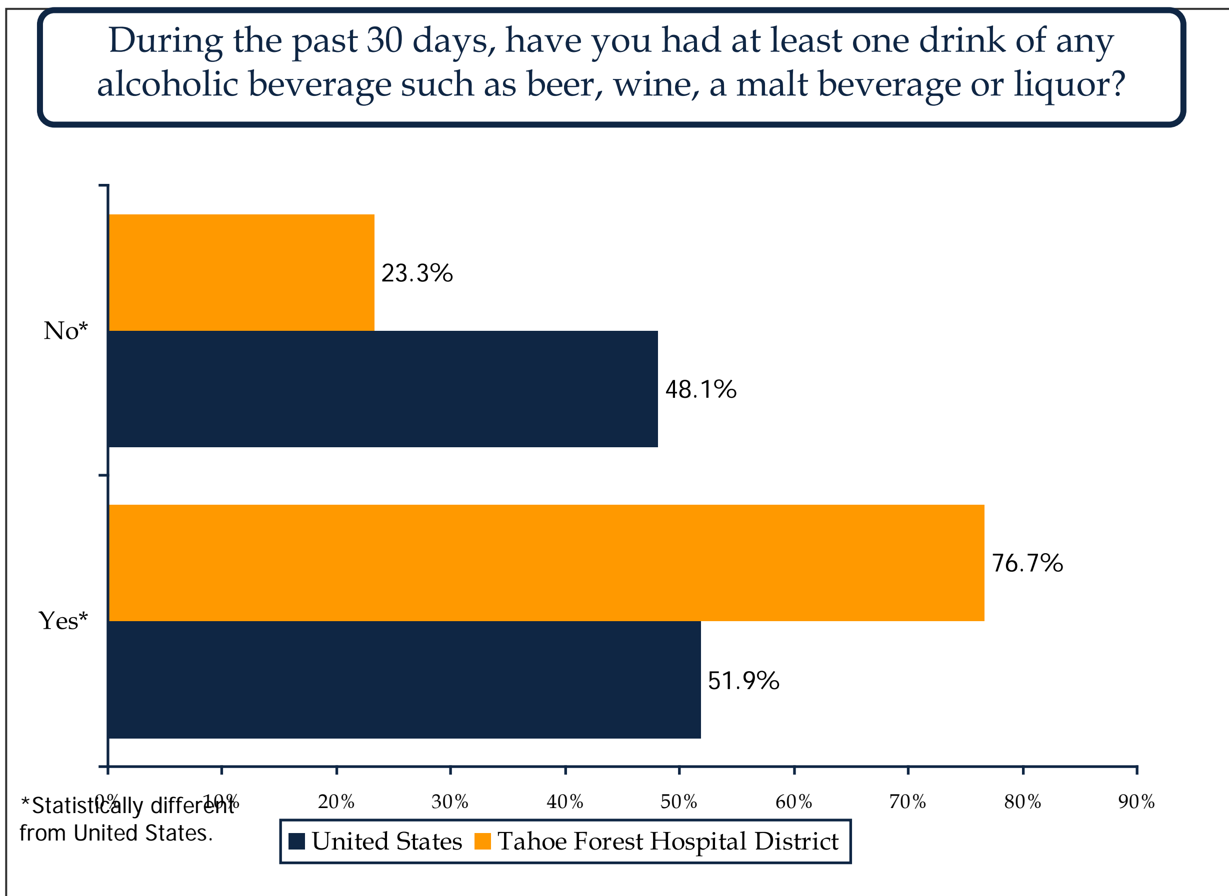
- Develop local court team to keep individuals with behavioral health issues from returning to the justice system by June 1, 2014;
- Create peer support programs to provide basic treatment or support to individuals with mental illnesses by June 1, 2014;
- Develop local tele-mental health programs to provide additional behavioral health treatment by June 1, 2014

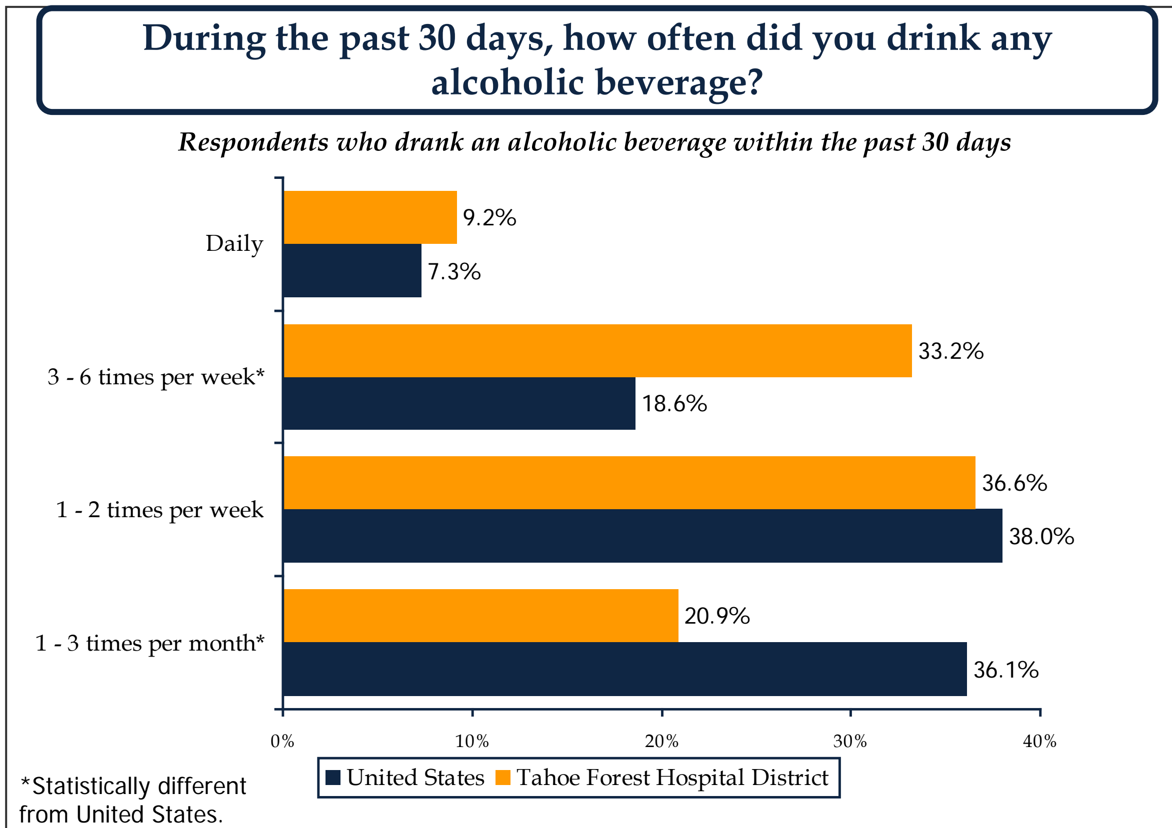
Potential data elements to collect and trend:

- Percentage of patients given depression screening during primary care/medical home visits
- Percentage of patients referred for intervention
- Percentage of those patients referred to intervention who are complying

Issue: Substance Abuse

On average, approximately 52% of Americans have at least one alcoholic drink in a typical month. Of the adults living in the area, collectively, almost 77% have at least one alcoholic drink in a typical month. That exceeds the national average by 25%. Statistics were also collected regarding consumption amounts. The assessment results suggest moderate levels of consumption by volume and no significant problem with binge drinking compared to national averages. While both genders demonstrate higher levels of alcohol consumption, males are above females in their monthly alcohol use. Additionally, Hispanic residents are significantly less likely to consume alcohol in a typical month (51%).





In addition to adult alcohol consumption, the following findings regarding student substance abuse were drawn from the community health needs assessment:

Lifetime Alcohol Use of 9th Graders – More TTUSD students have consumed a whole glass of alcohol (56.0%) when compared to California Unified School District (CUSD) students (39.0%).

Lifetime Marijuana Use of 9th Graders – More TTUSD students have smoked marijuana (32.0%) compared to CUSD students (21.0%).

Current Alcohol Use of 9th Graders – More TTUSD students consumed a glass of alcohol in the past month (33.0%) compared to CUSD students (22.0%)

Level of Alcohol Involvement with 9th Graders – More TTUSD students have been drunk or sick after drinking (36.0%) compared to CUSD students (21.0%).

OUR GOAL: *"We will reduce substance abuse in the community."*

Objective #1:
Form an education-, student- and (parent or) community-based coalition by November 1, 2011 to research student substance abuse, identify priorities and objectives to reduce or eliminate substance abuse, and agree on metrics and timelines for those objectives.

Examples of objectives this group may consider include:

- Outreach to 200 students by January 1, 2013 with training on when it may be a good time to seek help, or how to spot danger signals with peers
- Provide educational workshops to parents on how to prevent, identify and address potential drug abuse
- Co-promote "Alcohol Edu" with schools among students and their parents beginning January 1, 2012
- Create and provide physician training and support for intervention with student-age alcohol and drug abuse by June 1, 2012

Potential data elements to collect and trend:

- Number of patients attending support programs
- Number of referrals for substance abuse
- Track and trend Community Health Needs Assessment survey results over time
- Track and trend Town of Truckee monthly police reports on drug- and alcohol-related offenses (obtain also from County Sherriffs' offices by zip code if possible)

GAP SURVEY

One of the goals of the community health needs assessment was to not only identify the key community health issues, but to also evaluate existing resources with regard to each issue. The aim is to not develop redundant programs or services, and instead to identify gaps in what is available and supplement existing resources to address key health issues.

In August 2011, an informal electronic survey was distributed to the Community Health Needs Assessment Steering Committee membership asking for their input on known services and programs, and to gather feedback on perceived gaps in services. This chapter outlines their responses and provides a starting point in resource identification.

Access to Primary Care

Existing Strengths/Assets	Gaps
• Kings Beach Clinic • Placer County Public Health • Tahoe Forest Clinic • Existing provider networks	• Barriers exist due to limited office hours, availability of appointments, transportation and limited acceptance of insurances among providers • Too few bilingual/bicultural providers • Limited free/reduced care • Not a social norm among some to have a personal provider • Patient has to come to care; no outbound primary care options • Existing culture of going to ER for primary care • Fear and distrust among undocumented individuals • Motivation lacking among transient population to secure primary care provider relationship

Immunizations

Existing Strengths/Assets	Gaps

• Vaccines available at:
  ○ Stores/merchants (CVS, Safeway)
  ○ Kings Beach Clinic
  ○ Placer County Health Dept.
  ○ Nevada County Health Dept.
  ○ Occupational Health Clinic
  ○ Physicians' offices (not necessarily targeted to low income)
  ○ TFH Multi-specialty group (Pediatrics)
  ○ North Lake Pediatrics
  ○ WIC
  ○ North Tahoe Family Resource Center
• Strong promotions in newspapers, radio
• Can vaccines be provided as part of other treatment (e.g. ER, Urgent Care)?
	• Clinics could be better advertised
	• Long lines at clinics may be deterrent
	• Need for better education on importance of vaccinations (strength in doing this with partners)
	• Private physicians not an option for under- or uninsured
	• Better enforcement of "conditional status" might be needed within schools
	• Cost continues to be a deterrent
	• Budget cuts are reducing immunization clinics
	• Lack of transportation a barrier
	• Need for more education of Hispanic residents; too little culturally-appropriate outreach or materials
	• No mobile or outreach clinics for individual vaccines (schools, employers)

Mitigating Ethnic Disparities

Existing Strengths/Assets	Gaps

• Care for low income provided at:
  ○ Family Resource Centers in Truckee & North Tahoe offer resources
  ○ Kings Beach Clinic
  ○ Sierra Family Services
  ○ Health departments
  ○ Tahoe Forest Hospital Clinic
• Previous Community Health Fairs targeted at Hispanic/Latino community
• Bilingual staff at Kings Beach Clinic and Sierra Family Services
• Support from churches
	• Undocumented individuals are without access to health assistance programs
	• Affordable dental care programs are lacking
	• Need for more culturally sensitive care
	• There are too few Latino leaders who represent needs of population
	• Too few bilingual medical staff
	• Not a full understanding of health beliefs
	• Lack of trust among Hispanic population for health providers
	• Limited hours to access primary care among working poor

Mental Health

Existing Strengths/Assets	Gaps
• Mental health treatment/support services available at: o Sierra Family Services o Nevada County Behavioral Health o CORR (Community Recovery Resources) o Family Resource Centers o Private providers/counselors o Agape Center o Wrap around services o Peer Counseling by Welcome Center o Spirit Empowerment o Tahoe Safe Alliance counseling services	• Too few programs focusing on prevention/maintaining good mental hygiene • Medi-Cal coverage very limited • Need for more free or low-cost options • Existing agencies and resources are at maximum • Need for mobile and bilingual/ bicultural therapists • No/limited free or affordable counseling services • Limited treatment options for dually diagnosed (mental health & substance abuse) • Treatment options for certain demographic groups: seniors, youth • Transportation barriers

Substance Abuse

Existing Strengths/Assets	Gaps
• Substance abuse treatment/prevention services available at: o Sierra Family Services o CORR (Community Recovery Resources) • Twelve-step programs in the area (Alcoholics Anonymous; Narcotics Anonymous) • FWDD (Future Without Drug Dependence) prevention coalition	• Too few free/low cost drug and alcohol treatment programs • Juvenile Drug Court has no treatment component • Education regarding abuse of prescription medicines needed • No venues to dispose of expired/unused prescription meds • Need training of ER, primary care doctors in Screening, Brief Intervention, Referral and Treatment • Few evidence-based treatment options • No local treatment center for inpatient and outpatient • Need for transitional housing • Differences of opinion with what is/is not acceptable (e.g. marijuana use; drinking)

ADDITIONAL HEALTH CONSIDERATIONS

While the CHIP outlines the key health issues that were adopted as priorities, additional findings from the study are noteworthy. Other health issues that were revealed in the assessment may already be the focus of particular agencies, organizations, and providers, given their respective areas of concern. Additionally, these health issues may be the target of future efforts after initial progress with the five key issues detailed in this CHIP. These issues are on "watch" status to trend with future assessments.

- Women's Health:
  - The assessment revealed that females in the area are more likely to have barriers accessing care than males. For example, females were more likely to have cost as a barrier to accessing mental health treatment than males. The same pattern is present when looking at barriers to dental care, wherein females report more cost barriers than males.

- Oral Health Care:
  - Roughly 30% of area adults would like to seek help for dental health needs, but have been unable to for a variety of reasons. The two most common reasons were 1) a lack of insurance and 2) unable to afford the dental bills. This suggests that the most significant problems are amongst the un- and under-insured residents in the area.

- Weight:
  - Despite statistics that compare favorably to national averages, roughly half (49.5%) of area adults are overweight or obese. This translates into approximately 14,000 adults in the area who are living at an unhealthy weight. Additionally, as noted in previous sections, significant disparities exist in body weight across ethnic groups.

THE PATH AHEAD

By definition the CHIP process is a cyclical progression toward community health improvement. With the completion of the Community Health Improvement Plan, participants will advance to the program development phase. This part of the cycle consists of convening collaborative working groups to plan, implement and evaluate initiatives and interventions to reach measurable objectives. Success will come from a community-owned process and a commitment to collective goals.

Throughout the action cycle, progress will be assessed and tactics refined depending on what practices are yielding the most significant results. It is important to develop programs and outcomes that are measurable and easily tracked. It is better to set realistic, simple goals rather than difficult, complex ones. It is important to also have a few early successes to maintain commitment and momentum.

A typical action cycle based on a Community Health Improvement Plan spans 3-5 years. Keeping the issues at the forefront and a regular review of the CHIP will increase the likelihood of success.

Implementing a successful action plan will be highly dependent on our continued alliances. The Health System recognizes the need to maintain and strengthen our relationship with our physicians and partner agencies in the community and encourages the rest of the community's engagement as well.

COMMUNITY PARTNERS

We would like to thank all of the residents of the Tahoe Forest Hospital District who participated by taking the survey or attending a district meeting. We also share our deepest gratitude to the following organizations and individuals who served on the Steering Committee. The Community Health Needs Assessment Steering Committee represents a variety of local health and human services agencies, whose participation made our needs assessment possible. Without their support and contribution, the project would not have been successful.

Community Health Needs Assessment Steering Committee:

Lisa	Abrahams	Truckee Tahoe Unified School District
Analia	Batson	North Tahoe Family Resource Center
Stephanie	Blume	Project Mana
Richard	Burton, MD	Placer County
River	Coyote	Placer County
Ken	Cutler, MD	Tahoe Forest Health System
Sarah	Deardorff	Sierra Senior Services
Ann	Delforge	Sierra Senior Services
Margarita	deNavarez	At large
Steve	Dickinson	Tahoe Truckee Unified School District
Liz	Ewing	Tahoe Truckee Unified School District
Jim	Gandley, MD	Placer County
Adela	Gonzalez	Family Resource Center of Truckee
Kelli	Twomey	Tahoe City Public Utilities District
Glen	Harelson	Nevada & Placer Counties
Jon	Kerschner	Sierra Family Services
George	LeBard	Project Mana
Karen	Milman, MD	Nevada County
Alison	Schwedner	Community Collaborative of Truckee Tahoe
Mark	Starr, MD	Placer County
Holly	Whittaker	Nevada County
Colleen	Williams	Tahoe Forest Health System
Shawni	Coll, DO	Tahoe Forest Women's Center
Reini	Jensen, MD	Truckee Tahoe Medical Group

RESEARCH CONSIDERATIONS

A. Target Area:

The assessment focused on the following zip codes:

California (District boundaries)

96160 – Truckee – Nevada County
96161 – Truckee – Nevada County
96162 – Truckee – Nevada County
96140 – Carnelian Bay – Placer County
96142 – Tahoma – El Dorado County
96143 – Kings Beach – Placer County
96145 – Tahoe City - Placer County
96146 – Olympic Valley - Placer County
95724 – Norden – Nevada County
95728 – Soda Springs – Nevada County

Nevada

89451 – Incline Village – Washoe County
89450 - Incline Village – Washoe County

All research targeted representative statistics within each of these zip codes. There are a few instances (largely within the secondary data) where data was unavailable at the zip code level or where California and Nevada varied in their level of reporting. The data that were utilized to drive the prioritization process and CHIP conclusions is representative of all areas above. Any exceptions to this are noted accordingly.

B. Household Survey:

The household survey process followed a robust platform developed by the Centers for Disease Control, the Behavioral Risk Factor Surveillance System Survey (BRFSS). The BRFSS targets area adults to assess their health status and risk factors. For the current survey, custom questions were also added by the Steering Committee. A sampling strategy was developed to identify the number of completed surveys needed within each zip code in the Hospital District plus Incline Village, Nevada, to obtain a statistically representative sample. The final sample (473 interviews) yields an overall error rate of +/- 4.5% at a 95% confidence level. Data collection took place between February 1 and March 4, 2011.

REFERENCES

[i] On March 31, 2011, the Department of Health and Human Services (HHS) released proposed new rules to help doctors, hospitals, and other providers better coordinate care for Medicare patients through Accountable Care Organizations (ACOs) as part of the Affordable Care Act. ACOs create incentives for health care providers to work together to treat an individual patient across the spectrum of care. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients' needs first. Patient and provider participation in an ACO is purely voluntary. There are population requirements to become a true ACO. Our community does not meet those requirements; therefore, a prototype ACO is being considered.

[ii] The TFHD District boundaries are the legislated boundaries of our tax and voting area within portions of Nevada and Placer Counties, California. Those living outside of the District do not pay taxes into the District, nor may they vote on matters related to the District, including but not limited to the election of our Directors.

[iii] Healthy People 2020, www.HealthyPeople.gov (*Healthy People provides science-based, 10-year national objectives for improving the health of all Americans. For three decades, Healthy People has established benchmarks and monitored progress over time in order to: Encourage collaborations across sectors, guide individuals toward making informed health decisions and measure the impact of prevention activities.)*

[iv] www.who.int

[v] Joint Center for Political and Economic Studies, "The Economic Burden of Health Inequalities in the United States." September 2009.

[vi] National Institute on Drug Abuse, www.drugabuse.gov; Mental Health America, www.nmha.org