TAHOE FOREST HOSPITAL DISTRICT

2018-06-04 Special Meeting of the Board of Directors

Monday, June 4, 2018 at 10:00 a.m.

Eskridge Conference Room - Tahoe Forest Hospital

10121 Pine Avenue, Truckee, CA 96161

Meeting Book - 2018-06-04 Special Meeting of the Board of Directors

06/04/18 Special Meeting

Agenda

Item 1 - 4: See Agenda

5. Items For Board Discussion and/or Action

6. Adjourn

TAHOE FOREST HOSPITAL DISTRICT

SPECIAL MEETING OF THE BOARD OF DIRECTORS

AGENDA

Monday, June 4, 2018 at 10:00 a.m.

Eskridge Conference Room – Tahoe Forest Hospital
10121 Pine Avenue, Truckee, CA 96161

1. **CALL TO ORDER**

2. **ROLL CALL**

3. **DELETIONS/CORRECTIONS TO THE POSTED AGENDA**

4. **INPUT – AUDIENCE**

   This is an opportunity for members of the public to address the Board on items which are or are not on the agenda. Please state your name for the record. Comments are limited to three minutes. Written comments should be submitted to the Board Clerk 24 hours prior to the meeting to allow for distribution. Under Government Code Section 54954.2 – Brown Act, the Board cannot take action on any item not on the agenda. The Board may choose to acknowledge the comment or, where appropriate, briefly answer a question, refer the matter to staff, or set the item for discussion at a future meeting.

5. **ITEMS FOR BOARD DISCUSSION AND/OR ACTION**

   5.1. Wellness Neighborhood

   The Board of Directors will review and discuss the Wellness Neighborhood's impact on board initiatives.

   5.1.1. Impact on Board Initiatives 2011-2017 ..... ATTACHMENT

   5.1.2. 2017 Annual Report ..... ATTACHMENT

6. **ADJOURN**

The next regularly scheduled meeting of the Board of Directors of Tahoe Forest Hospital District is June 28, 2018 at 11603 Donner Pass Rd., Truckee, CA. A copy of the Board meeting agenda is posted on the District's web site (www.tfhd.com) at least 72 hours prior to the meeting or 24 hours prior to a Special Board Meeting.

*Denotes material (or a portion thereof) may be distributed later.

Note: It is the policy of Tahoe Forest Hospital District to not discriminate in admissions, provisions of services, hiring, training and employment practices on the basis of color, national origin, sex, religion, age or disability including AIDS and related conditions.

Equal Opportunity Employer. The meeting location is accessible to people with disabilities. Every reasonable effort will be made to accommodate participation of the disabled in all of the District's public meetings. If particular accommodations for the disabled are needed (i.e., disability-related aids or other services), please contact the Executive Assistant at 582-3481 at least 24 hours in advance of the meeting.

Wellness Neighborhood

IMPACT ON BOARD INITIATIVES – 2011-2017

PRESENTED: JUNE 4, 2018

MARIA MARTIN, MPH, RDN, DIRECTOR COMMUNITY HEALTH & WELLNESS

Community Health and Wellness

Works to build and support a culture of health through:

- Promote a culture of health
- Support those with chronic disease to improve their quality of life
- Foster community collaboration and partnership
- Integrate health services and improve the customer experience

Overview

Community Health and Wellness works collaboratively to maximize our impact.

We partner with:

TFHD Departments: Wellness at Work, Center for Health, PRIME, Care Coordination, MSC, Cancer Center

Community Partners: TTUSD, TTFWDD, Gateway Mountain Center, Truckee and NT Family Resource Centers, Project Mana, Community Collaborative of Truckee Tahoe , Suicide Prevention Coalition, Placer and Nevada County, TTMG

Objectives for Today

- Understand the process of the CHNA
- Understand the impact of current programming on the four Board Initiatives
  1. Optimize Health and Preventive Health Services
  2. Access to Care and Care Coordination
  3. Reduce Substance Misuse
  4. Access to Mental and Behavioral Health Resources
- Identify opportunities for improvement
- Next Steps

What is a CHNA?

A Community Health Needs Assessment (CHNA) is a systematic process involving the community to identify and analyze community health needs and assets in order to prioritize these needs, and to plan and act upon unmet community health needs.

How do we use the CHNA?

The CHNA informs community partners and the health system in improving the health of our community. Success is dependent on community partnership and support from the entire health system.

TFHD CHNA TIMELINE

Working to build and support a culture of health

Feb 2017
Leading

Define the Lead Team

May 2017
Consulting

Identify & Secure Surveyor:
Franklin & Marshall College

Jun 2017
Collaborating

Convene Community Advisory Group

Aug - Jan 2018
Collecting

Finalize Survey Tool and Data Collection including the addition of Focus Groups

Jan - Jun 2018
Analyzing and Reporting

Data Interpretation and Results Reporting
Gathering Community Feedback and Prioritization of Health Needs

Jun - Aug 2018
Planning

Community Health Improvement Planning
- Community Prioritization of Health Needs
- Magnitude
- Impact/Seriousness
- Feasibility
- Consequence of Inaction

Sep 2018
Sharing

TFHD Board Presentation: CHIP

Wellness Neighborhood Board Initiatives 2014

Optimize Health and Preventive Health Services

Access to Care and Care Coordination

Access to Mental and Behavioral Health Resources

Reduce Substance Misuse

Board Initiative Presentation Framework

1. Optimize Health and Preventive Health Services

Optimize Health and Preventive Health Services Goals

Optimize Health and Preventive Health Services

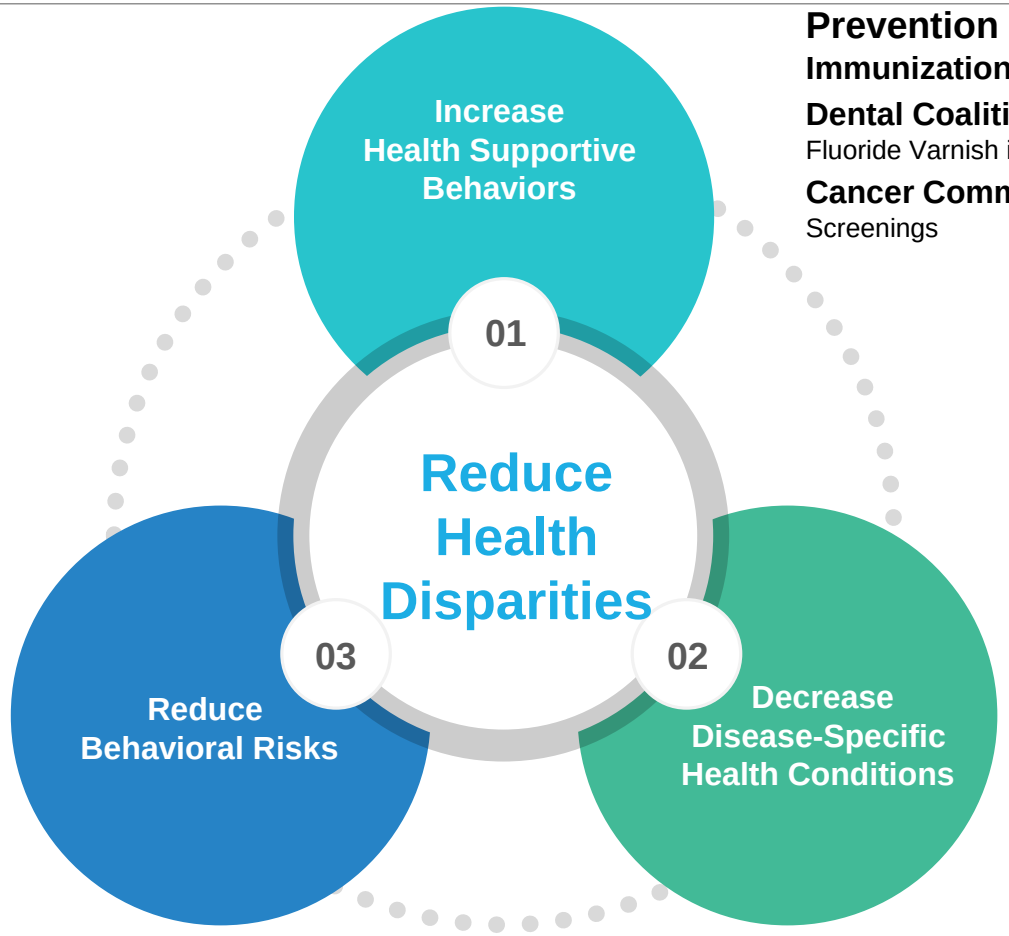
2017 Goals:

- Decrease disease-specific health conditions
- Increase health supportive behaviors
- Reduce behavioral risks
- Reduce health disparities

2011 Goals:

- No inequities in health with regard to ethnicity.
- Improve immunization and aim to reduce vaccine preventable diseases.
- Multidisciplinary group committed to improving oral health outcomes in children.

Optimize and Prevent



Prevention

Immunization Coalition: School Immunizations, HPV, Flu

Dental Coalition: School-based screenings, Outreach and Education, Fluoride Varnish in Peds Clinic

Cancer Committee (support accreditation): HPV, Colon Cancer Screenings

Education

B-Fit

Harvest of the Month

Cooking Matters

Kick Nicotine

"Rethink Healthy" Community Talks

Health Challenges

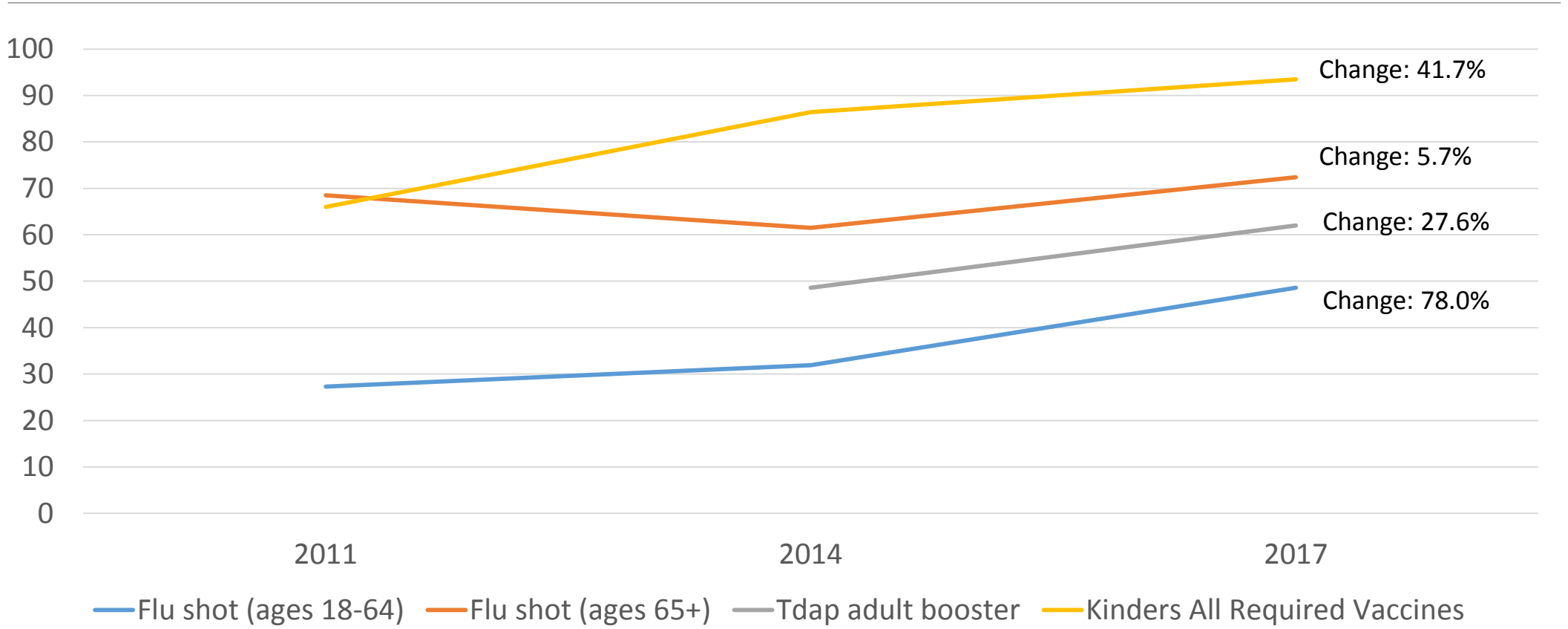
Early Detection

Prevent T2

Affordable Lab

PRIME Million Hearts

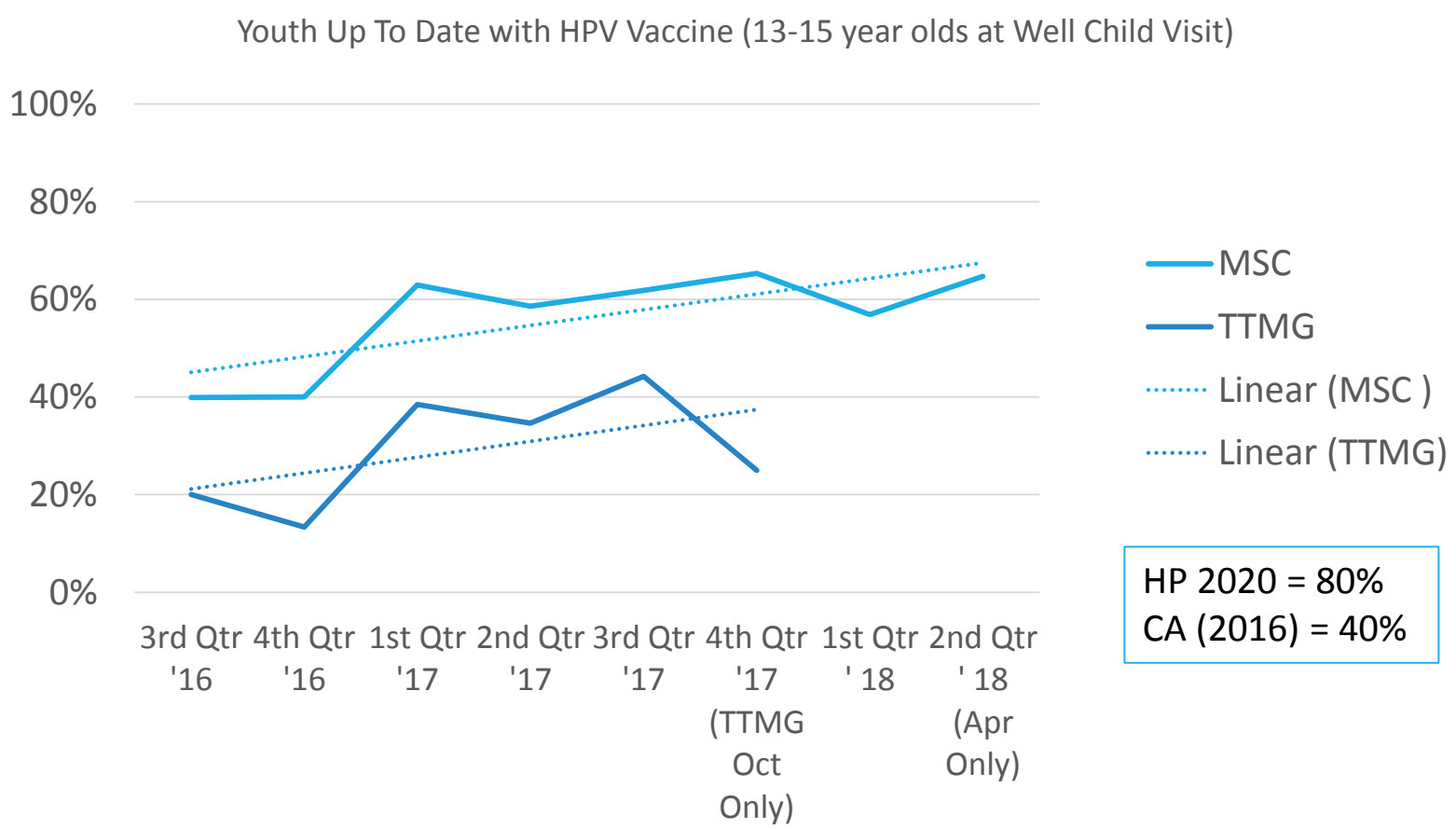
Optimize and Prevent: Increase Health Supportive Behaviors Immunizations



Optimize and Prevent: Increase Health Supportive Behaviors Immunizations

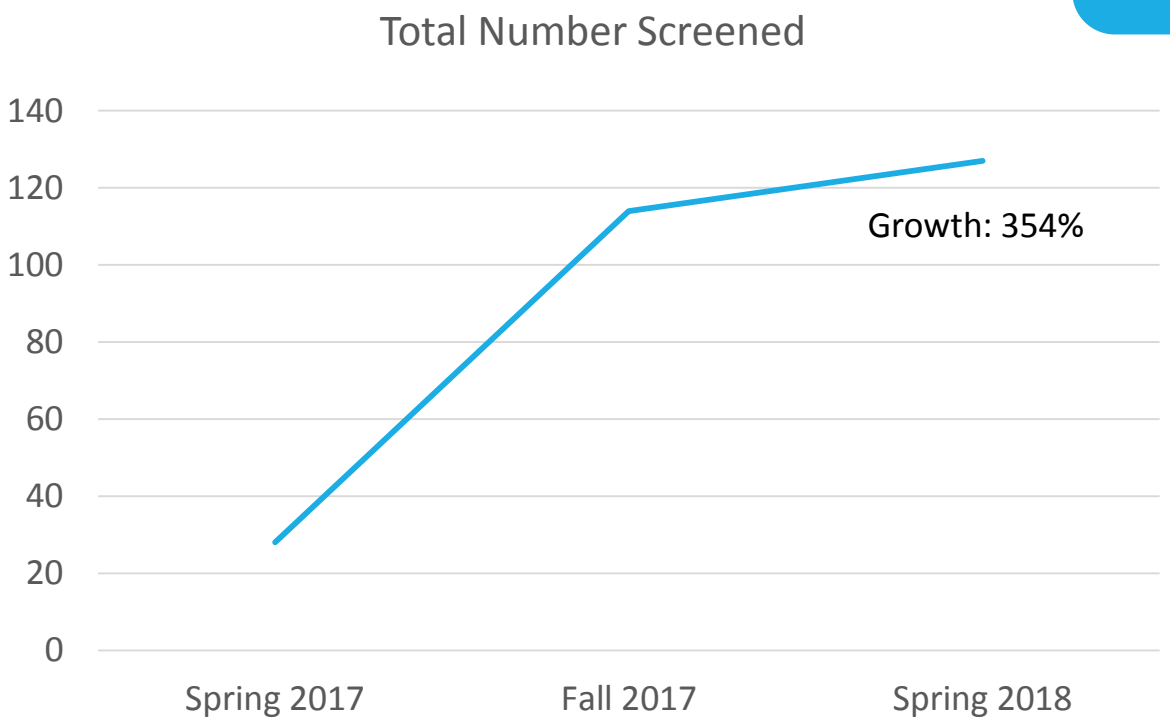
Wellness Neighborhood supports Cancer Center in meeting standards for accreditation

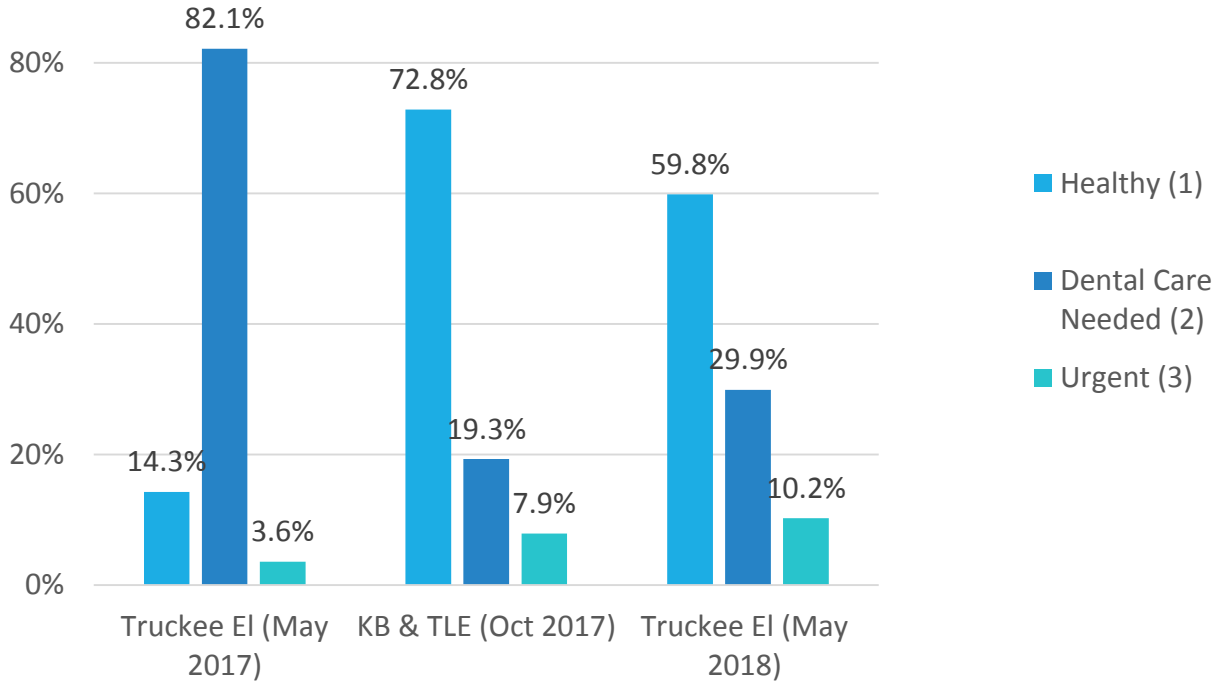
- 1.8 - Evaluations
- 4.1 – Prevention
- 4.2 – Screenings



Optimize and Prevent: Increase Health Supportive Behaviors
Dental Screening

We envision a community where all children have access to regular, preventive dental services, and oral health education to support healthy dental habits and optimal health.





Optimize and Prevent:
Increase Health Supportive Behaviors

CHNA Indicators	2011	2014	2017	BRFSS CA, NV
Ever had colonoscopy/sigmoidoscopy (age 50+)	74.2	70.3	77.6	71.4, 62.2
Routine check-up with a doctor in past 12 months	54.4	59.5	57.9	67.0, 69.1
Has seen dentist in past year	***	73.9	82.3	67.1, 60.4
Has had flu shot in past year (ages 18-64)	27.3	31.9	48.6	26.9- NV
Has had flu shot in past year (ages 65+)	68.5	61.5	72.4	58.1, 54.1
Avoids or never uses health care system	***	***	12.2	***

Optimize and Prevent: Decrease Disease Specific Health Conditions Diabetes

Prevent T2 data (April 2017-April 2018)

Completion Rate	Avg wt loss – 6 mo	Avg wt loss – 12 mo	Met wt loss goal of at least 5%	Total wt loss – all	Avg wt loss/ participant	Avg min of physical activity/ person/wk	Avg min of physical activity/ person/wk – CDC guidelines
80% (8/10)	5.1%	4.5%	4 participants	70 lbs	9 lbs	219	150

- "The course has motivated me to be much more aware of how my dietary choices affect my health. I've learned to track my food intake and my exercise, and to be more purposeful in the daily choices I make. I am meeting my goals and feel much better as a result… the support and insight from the nine other group members is also a valuable resource. I recommend the Prevent T2 course for anyone interested in becoming more active, healthy and aware!" Doug Jones

Optimize and Prevent: Decrease Disease Specific Health Conditions Heart Health

PRIME Million Hearts Program

GOAL: To address high risk MediCal patients with evidenced based protocols and preventative screening tools.

PRIME Metrics	2016	2017
Controlling BP	73%	76%
Preventative Care and Screening for HTN	10%	57%
Tobacco Screening	82%	80%
IVD and ASA	67%	88%

Community BP Screening

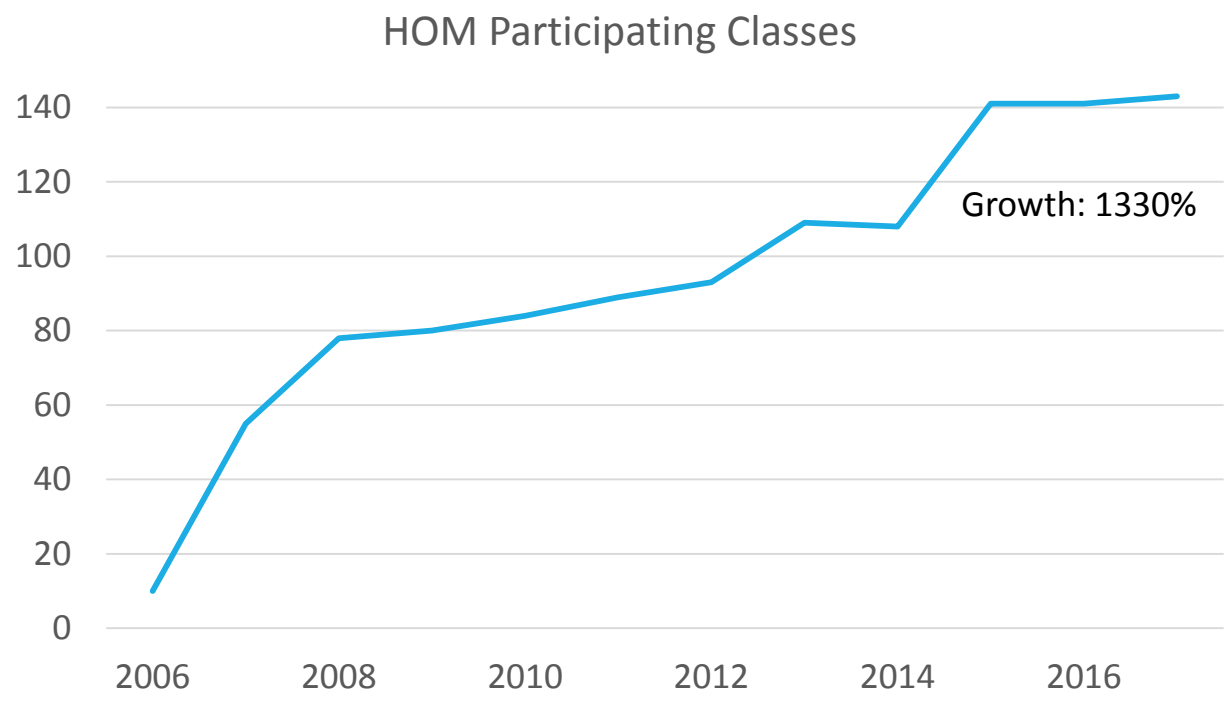
Project Mana, Affordable labs, FRC Wellness Days, and other community events

	Total Screened	Elevated BP	Immediate referral
FY18	473	29%	19

Optimize and Prevent:
Decrease disease-specific health conditions

CHNA Indicators	2011	2014	2017	BRFSS CA, NV
Has high cholesterol	36.3	24.7	36.5	34.2, 36.7
Ever diagnosed with high blood pressure	20.7	25.5	24.7	28.5, 28.3
Told has heart disease, heart attack, or stroke	1.4	***	7.2	NA
Respondent is diabetic	2.7	***	3.9	NA
Has ever had cancer	***	***	9.9	NA

Optimize and Prevent: Reduce Behavioral Risks
Harvest of the Month



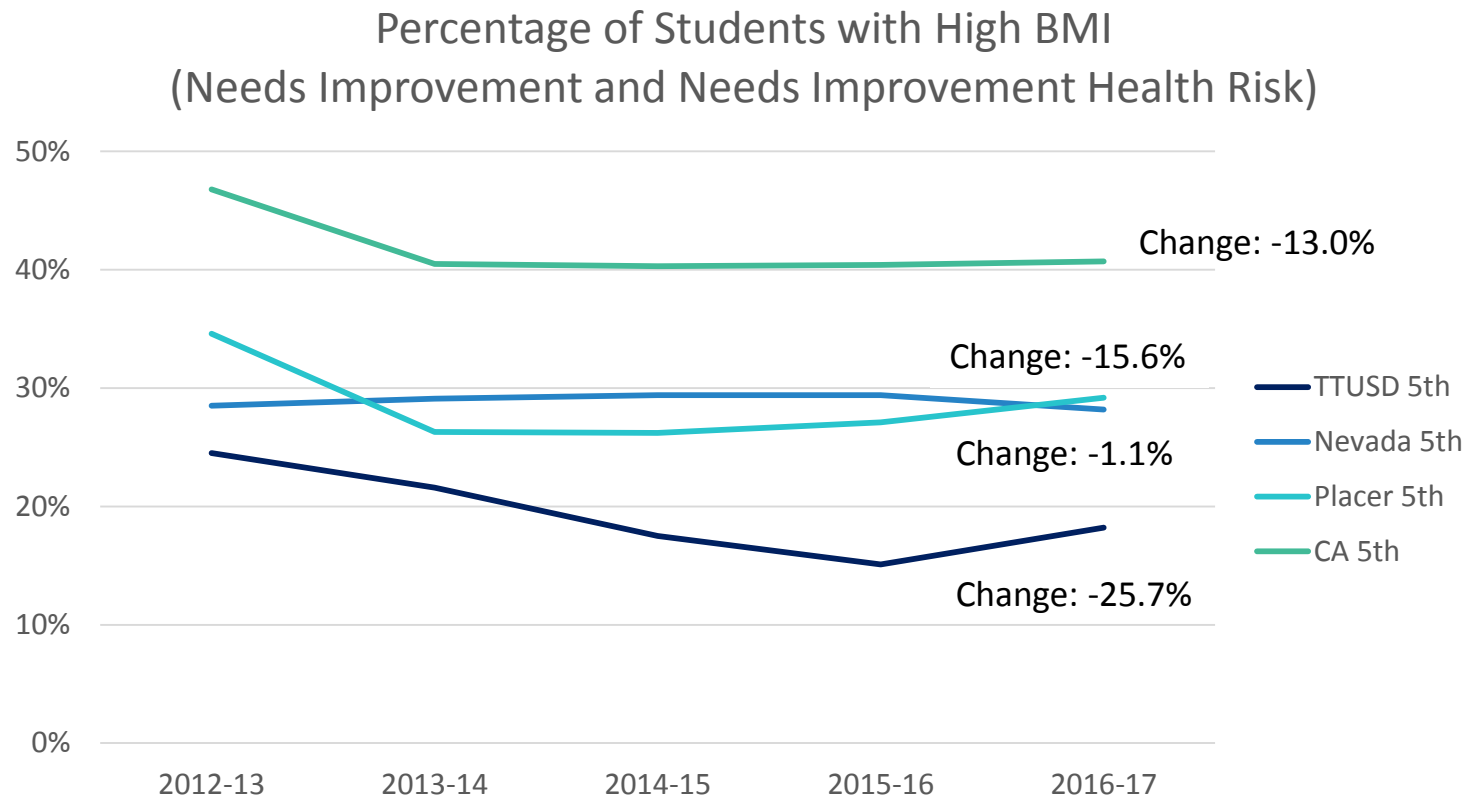
HOM Volunteer and Teacher Testimonials:

- "It really gets the kids excited about fruits and vegetables. I love when my own child comes home and talks excitedly about healthy foods."
- "Students tried things they had never tasted and liked them! Students appear to be choosing a variety of fruits and vegetables at hot lunch."

Optimize and Prevent: Reduce Behavioral Risks
B-Fit

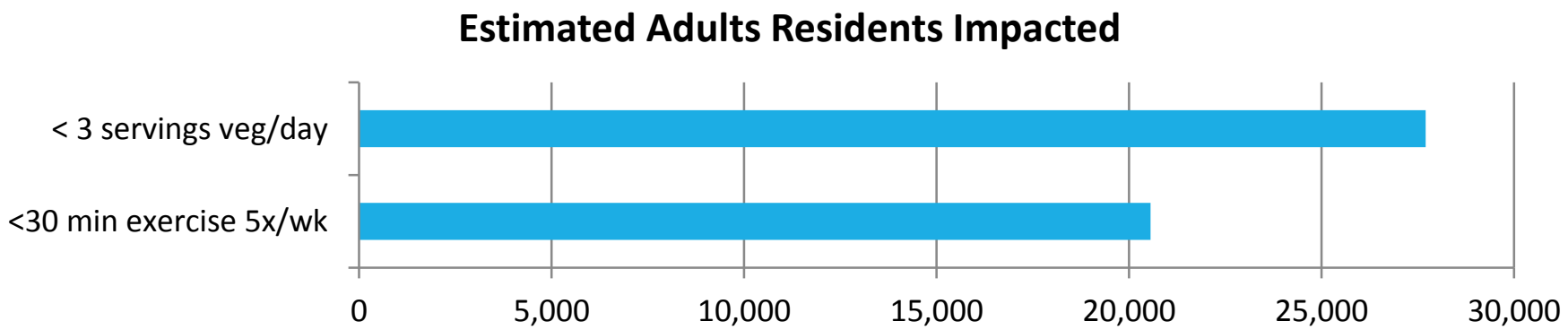
B-Fit Teacher Testimonials:

- "Students are more calm and focused after an activity. I can connect and reference information learned in B-Fit wellness lessons to other curriculum."
- "I noticed how the kids really wanted to make a point in telling me that they were being active as they were proud of themselves!"



Optimize and Prevent: Reduce Behavioral Risks

CHNA Indicators	2011	2014	2017	BRFSS (CA, NV)
BMI: Overweight and Obese	48.9	***	48.5	61.0, 62.3
Exercised 30 minutes on 5 days in past week	***	***	34.4	NA
Consumed 3 servings of vegetables daily	***	***	11.6	***



2. Access to Care and Care Coordination

Access to Care and Care Coordination

Access to Care and Care Coordination

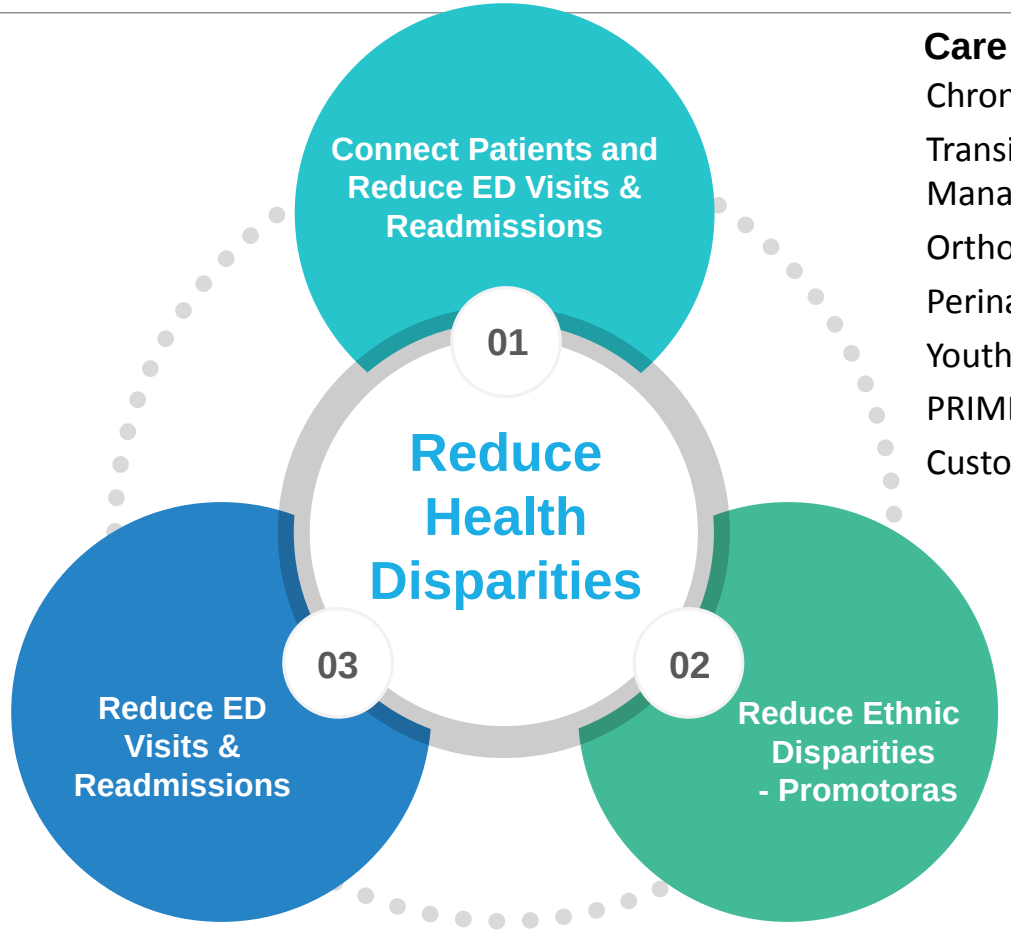
2017 Goals

- Reduce unnecessary ED visits and readmissions
- Reduce ethnic disparities
- Connect patients to PCP and community services

2011 Goals

- Identify and access a primary care provider (medical home).
- Develop a “Community Care Program” for Chronic Disease Management

Access and Coordination



Care Coordination

Chronic Care Management

Transitional Care Management

Orthopaedics

Perinatal

Youth Health

PRIME (MH and Pain)

Customer Care Navigators

Self Management Programs (SMP)

Chronic Disease SMP

Diabetes SMP

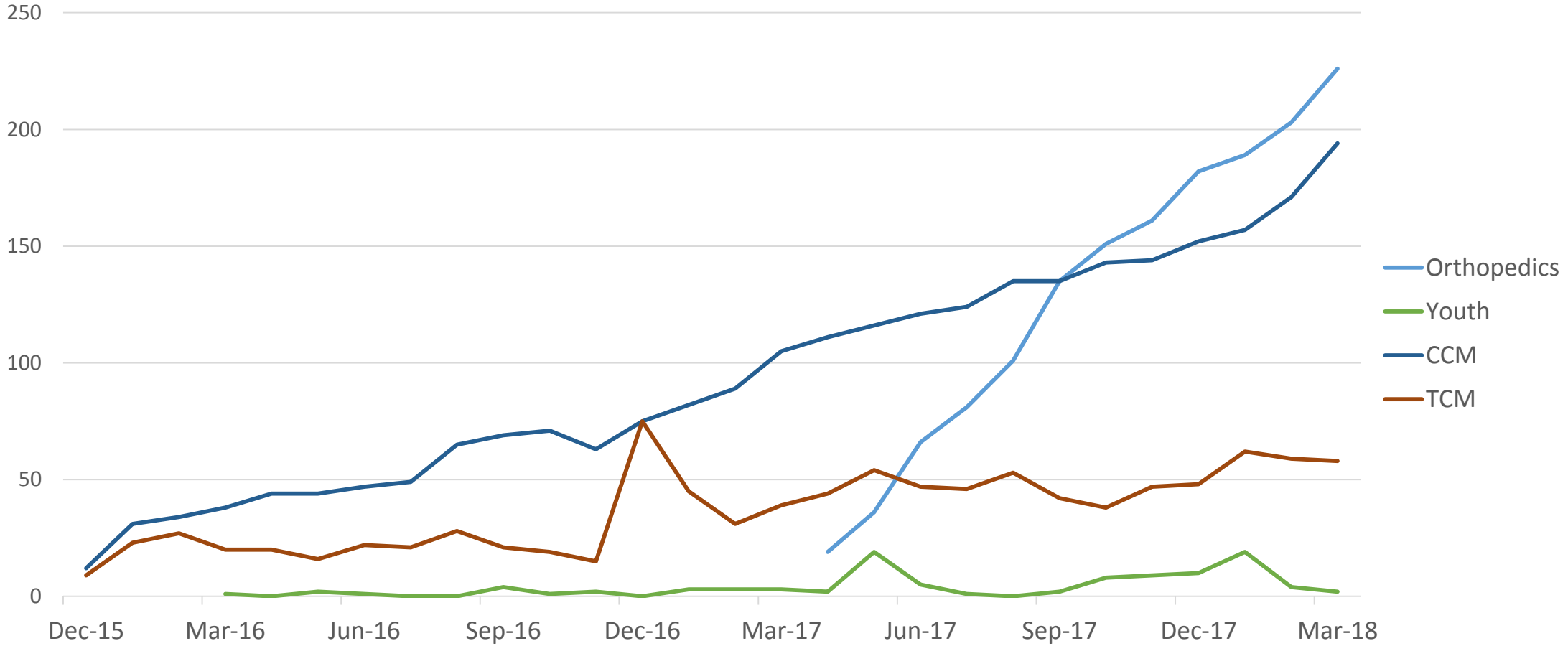
Chronic Pain SMP

Collaboration

Family Resource Center Promotoras

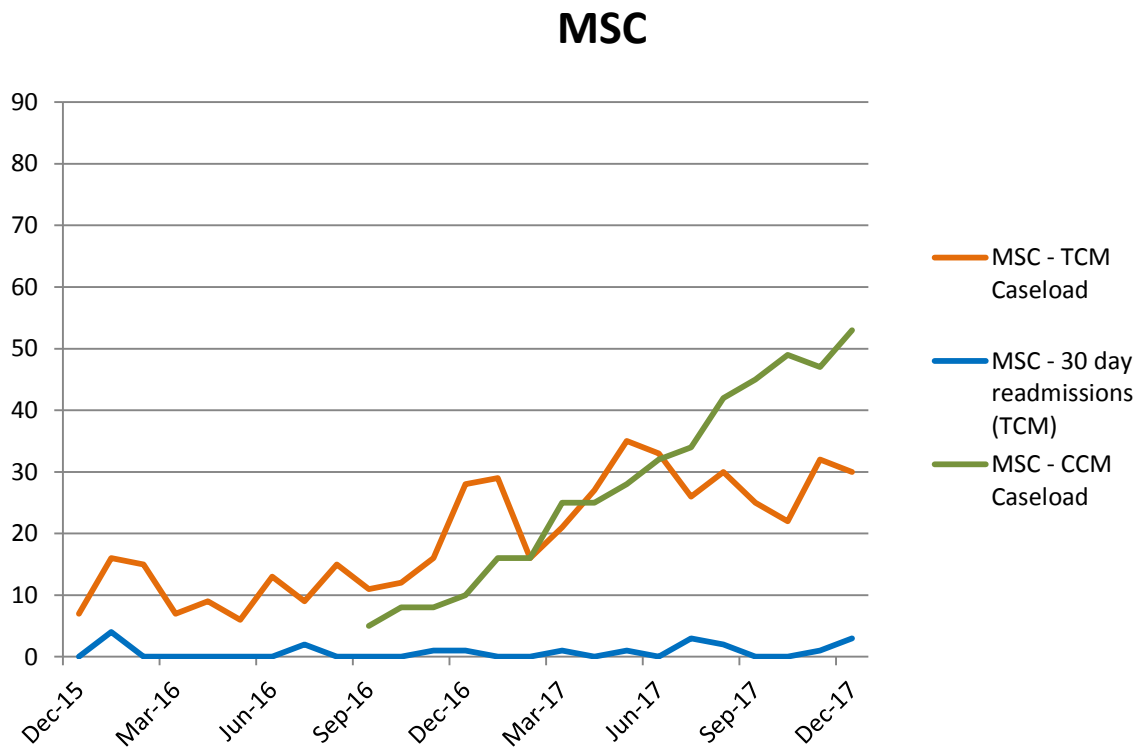
TFHD Community Health Advocates

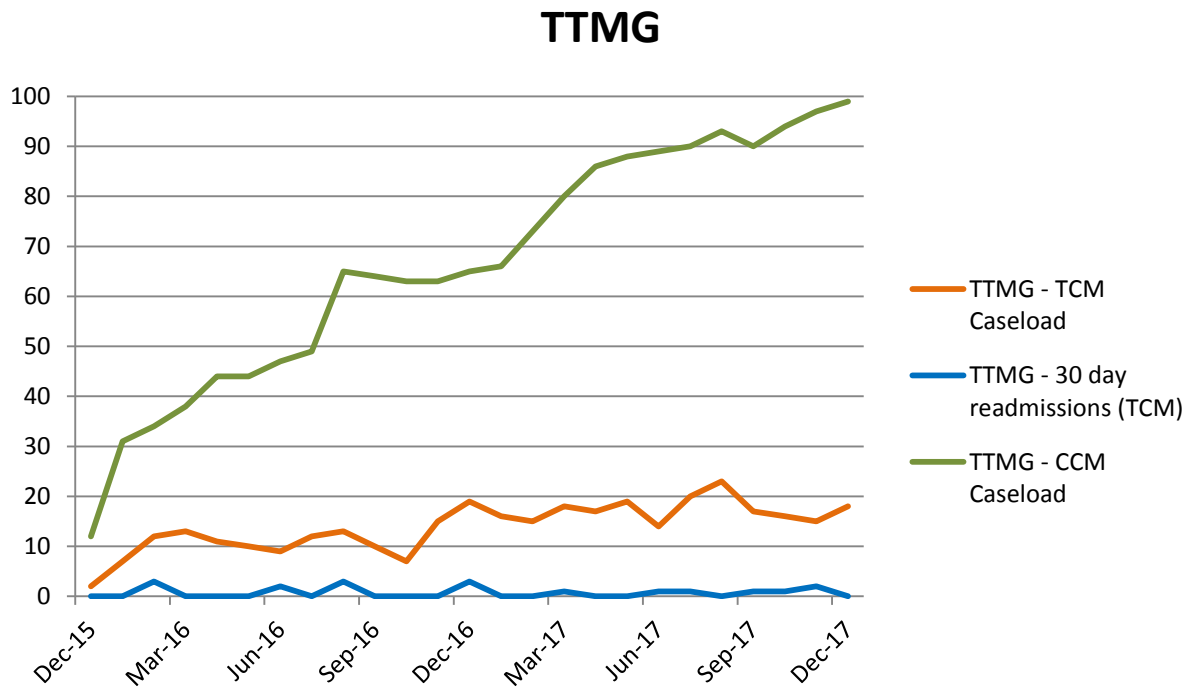
Access and Care Coordination: Connect Patients
Care Coordination Timeline



Access to Care: Reduce Readmissions
TCM

Average readmission rate of TCM patients (Medicare)
MSC = 3.8% TTMG = 5.2% National Medicare Avg. = 17.8%





Access to Care: Reduce Ethnic Disparities Collaboration and Self-Management Programs

Self- Management Class Program Participants

- FY17: 111 Participants
- FY18: 105 participants to date

Participant Testimonial:

How has this program impacted you and your ability to cope with your health condition?

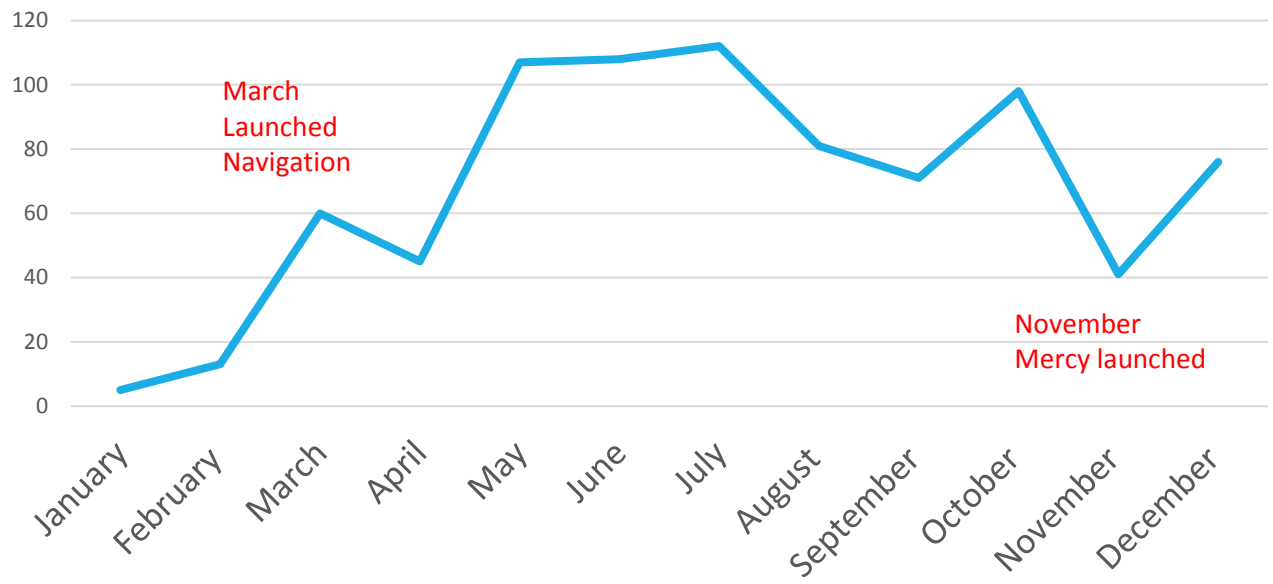
- *It has given me coping skills and I am confident that I will use what I have learned*.

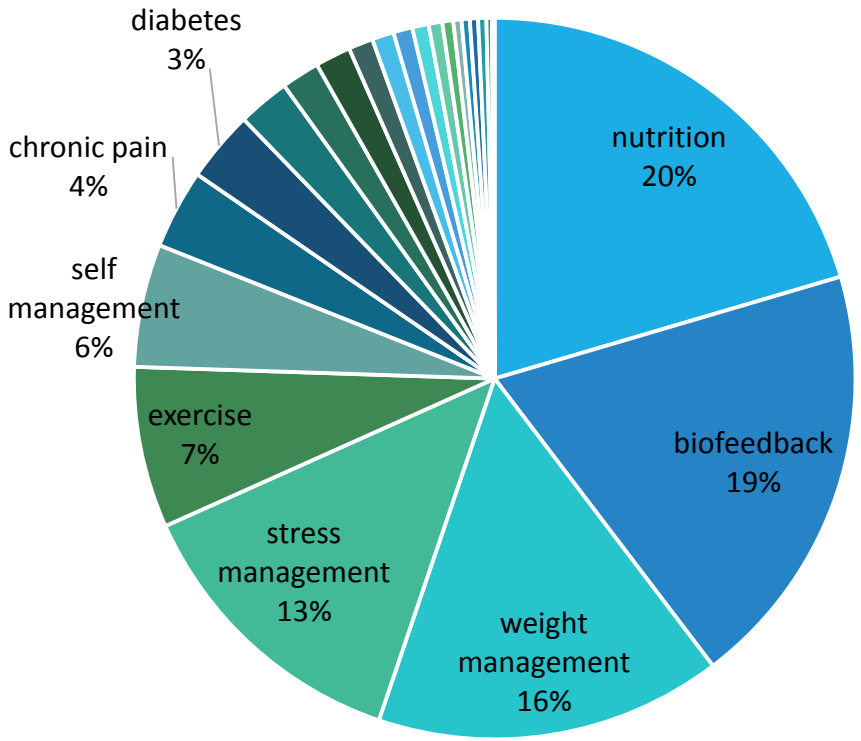
Access to Care: Reduce Ethnic Disparities Collaboration and Self-Management Programs

Diabetes Self Management Program	Pre	Post	% Change
In general, how is your health? (% Excellent or Very Good)	55%	100%	80%
How confident are you that you can keep the physical pain from interfering with things you want to do? (Scale of 0-10)	7.33	9.00	23%
Do you feel you can ask your PCP questions about your Rx plan? (% Yes)	78%	100%	29%
In the last week, how many days did you participate in physical activities?	2.63	4.20	60%
In the last week, how many days did you eat 5+ servings of fruits or vegetables?	3.67	5.25	43%
In the last week, how many days did you take your diabetes medication as directed?	3.50	5.25	50%

Self-reported Pre versus Post values

Access to Care: Connect Patients Customer Care Navigation





"I am so grateful that Liz helped me find transportation to my doctors appointment. She made a big difference in my life yesterday. Her compassion, willingness to help and to listen isn't something I experience a lot and it helped me tremendously."

Access to Care and Care Coordination

CHNA Indicators	2011	2014	2017	BRFSS (CA, NV)
Uninsured (<65)	25.3	16.8	4.8	10.8, 17.9
Has personal physician	67.5	66.0	71.1	76.0, 66.8
Did not receive health care in past year because of cost	17.3	12.9	4.4	11.4, 15.1
Limited access to care*	***	***	14.2	***
Economic hardships (1 or more)	***	***	22.9	***
No health insurance any time during past year (18-64)	***	***	9.2	***

3.Reduce Substance Misuse

Reduce Substance Misuse

Reduce Substance Misuse

2017 Goals

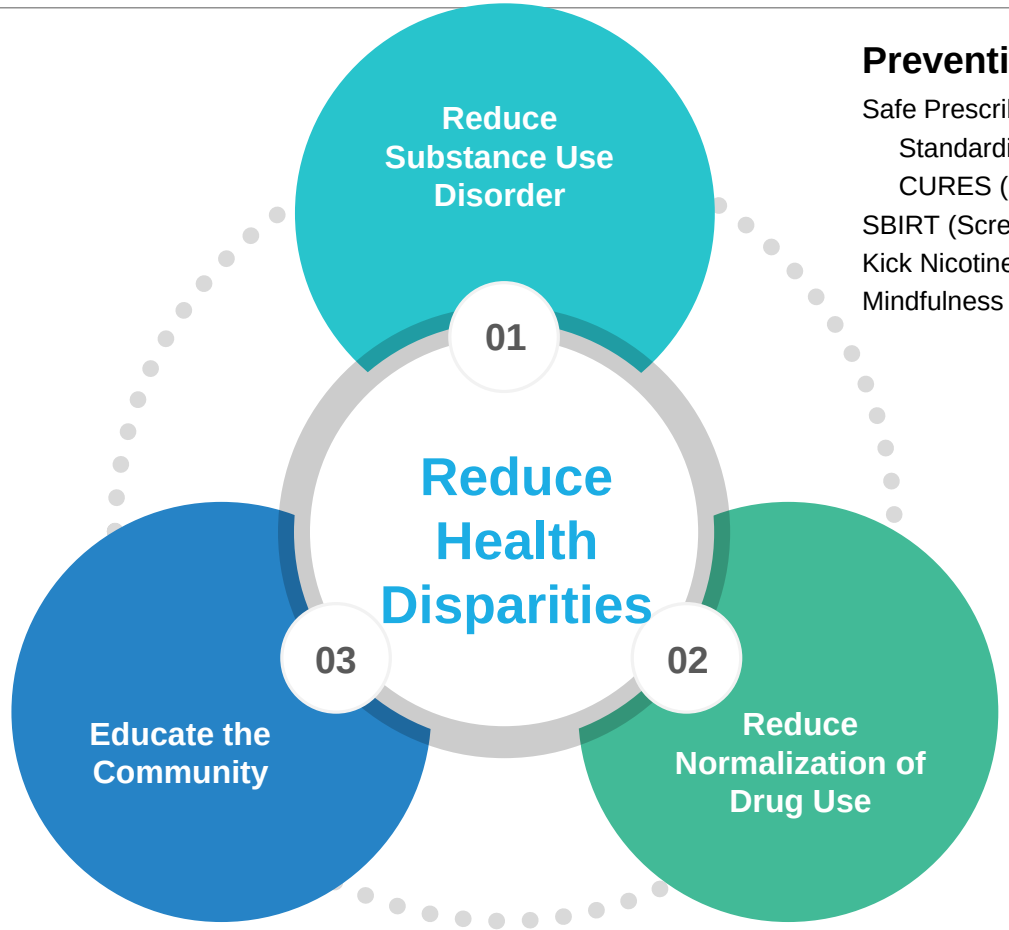
- Reduce substance use disorder
- Reduce the normalization of drug use, with an emphasis on school-aged children
- Educate the population on the risks of alcohol, prescription, and recreational drug abuse

2011 Goals

We will reduce substance abuse in the community.

- Implementation of Alcohol EDU at local high Schools
- SBIRT in Primary Care

Reduce Substance Misuse



Prevention

Safe Prescribe Practices
- Standardized provider medication agreement
- CURES (Controlled Substance Utilization Review and Evaluation)

SBIRT (Screening, Brief Intervention and Referral to Treatment)
Kick Nicotine
Mindfulness Based Relapse Prevention

Education

Alcohol EDU
Community Marijuana Workshops
Chronic Pain SMP
Multimodal Therapies for Chronic Pain
MBSR for Chronic Pain

Culture Shift / Environmental Change

Tahoe Truckee Future Without Drug Dependence
Community Marijuana Workshops
Athletes Committed
Rx Drug Takeback

Reduce Substance Misuse: Reduce Substance Use Disorder Safe Prescribe Practices

Utilize CDC Guidelines

Developed Policies and Procedures (Safe Prescribe)

Implemented workflow processes (EHR)

- Screening Tools

PRIME Metric (Medi-Cal Only)	2016	2017	2018 (Jan-Apr)
SBIRT/CRAFFT	2%	9%	38%
CURES	9%	9%	26%
MED AGREEMENT & URINE TOX	5%	9%	26%
TRMT OF CHRONIC PAIN W MULTIMODAL THERAPY	76%	84%	84%

Reduce Substance Misuse:Reduce Substance Use Disorder
Kick Nicotine

Mindfulness-based Stress Reduction and Relapse Prevention Model

- 62 Referrals
- 31 Received support and counseling
- 21/31 (68%) Reduced or Quit

Reduce Substance Misuse: Reduce normalization of drug use Marijuana and Rx Take Back

Marijuana

Community Education and Awareness

- Cannabis Summit
- Active Involvement in Town Council Meetings
- TFHD Official statement

Impact

- Narrowing of commercial options from cultivation and retail dispensaries to delivery service only (medical and adult recreational).
- Moratorium on commercial dispensaries

Rx Take Back

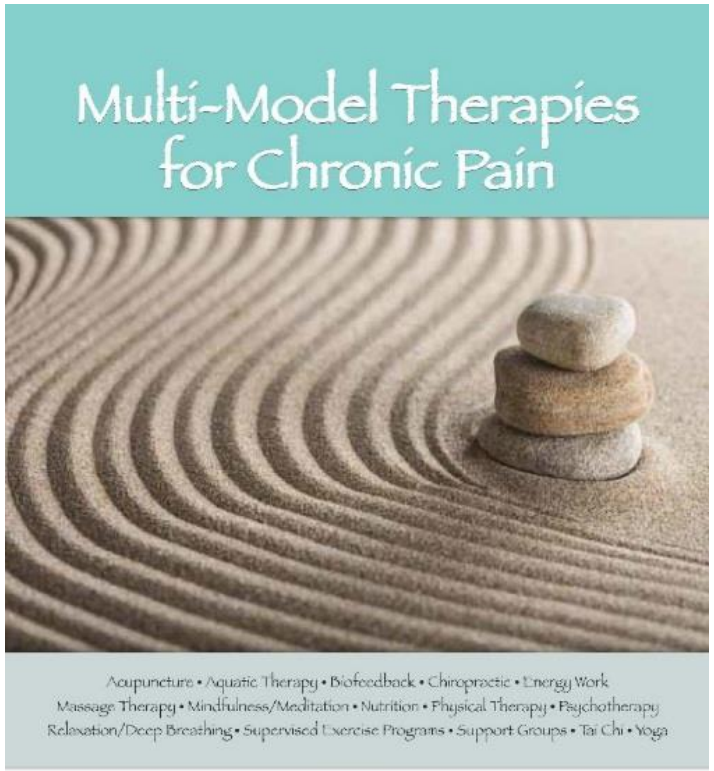
Take Back Events – 2/year

Permanent Bin – 2 locations available year round

- **641.8 lbs** total collected between 10/28/17 and 4/28/18
- **3559 lbs** collected since 2010

Reduce Substance Misuse: Educate the Community Chronic Pain

	Program Launch	# of Classes to Date	Total Participants
Self Care Modalities	November 2017	2	15
Chronic Pain Self Management Program	June 2017	2	25
MBSR for Chronic Pain	November 2017	2	30



wellnessneighborhood

Reduce Substance Misuse: Educate the Community
Project ECHO

UCDAVIS HEALTH
Center for Advancing Pain Relief

UC Davis ECHO® Pain Management
2018 Telementoring Schedule*

Project ECHO	# of classes	# of participants
2017	47	372
2018	12	99

CME's: Chronic Pain, CDC Guidelines for Opioid Best Practice Prescribing, Medication Safety, Medication Assisted Therapy, PDMP

Reduce Substance Misuse – Educate the community
AlcoholEDU

2016/17 School Year

- 266 students
- 2 Schools
  - North Tahoe and Truckee High
- 216 hours of learning

After completing *AlcoholEDU for High School*, students reported that the course prepared them to:

(% of students who agree or strongly agree that the course prepared them.)

Avoid riding in a vehicle driven by someone who has been drinking.	88%
Stop a friend from driving drunk.	86%
Establish a plan ahead of time to make responsible decisions about drinking.	84%
Resist social pressure to drink alcohol.	81%
Identify when someone has consumed too much alcohol.	81%

Reduce Substance Misuse

CHNA Indicators	2011	2014	2017	BRFSS (CA, NV)
Current smokers (not e-cigarettes)***	6.2	7.7	9.9	11.0, 16.5
Binge drinking behavior*	21.6	24.6	28.3	16.3, 15.8
Used illegal drugs in past year	***	***	3.4	***
Any substance use**	***	***	34.0	NA
Have a child <18 who used drugs or had a drinking problem (past 12 months)?	***	***	0.0	***

***Binge drinking behavior**: males having 5 or more drinks on one occasion or females having 4 or more drinks on one occasion. (CDC)
****Substance Use**: binge drinking, use of non-prescribed painkillers, stimulants or tranquilizers, or use of marijuana 20+ times in past 20 days.
***** **Current smokers**: asked only of those who have smoked at least 100 cigarettes

4. Access to Mental and Behavioral Health Resources

Access to Mental and Behavioral Health Resources

Access to Mental Health and Behavioral Health Resources

Current Goals

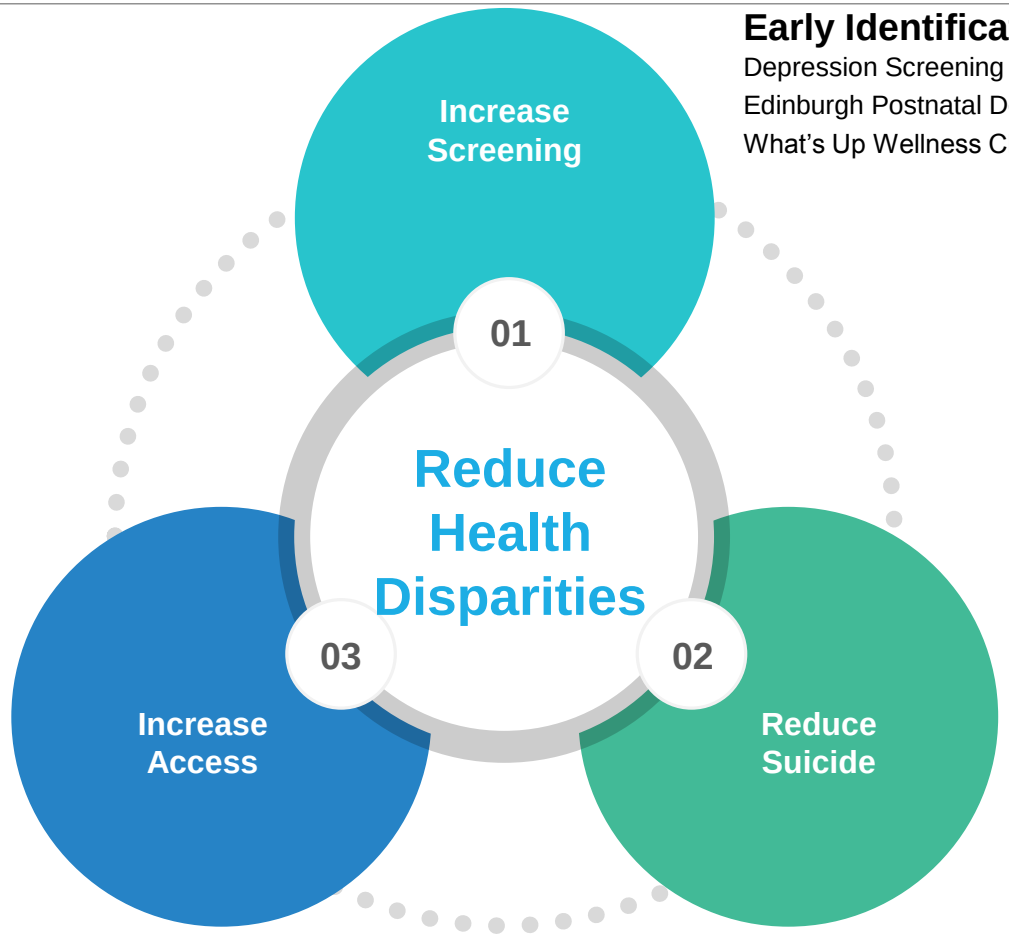
- Increase screening of mental health needs
- Increase access to mental health care
- Reduce disparities
- Reduce suicide rate

2011 Goals

Our residents will enjoy good mental health and those in need will have access to prevention and treatment.

- Co-location and integration of behavioral health services in primary care and Care Coordination
- Expansion of services for psychiatry and tele-psychiatry and tele-mental health care

Mental and Behavioral Health



Early Identification

Depression Screening (PHQ 9)

Edinburgh Postnatal Depression Screening

What's Up Wellness Check Ups (TTUSD)

Support

Perinatal Care Coordination/PMAD Counselling

Behavioral Health Care Coordination

TFHD Social Service

Gateway Mountain Center

Truckee/North Tahoe Mental and Behavioral Health Resource Directory

Community Collaboration

Suicide Prevention Coalition

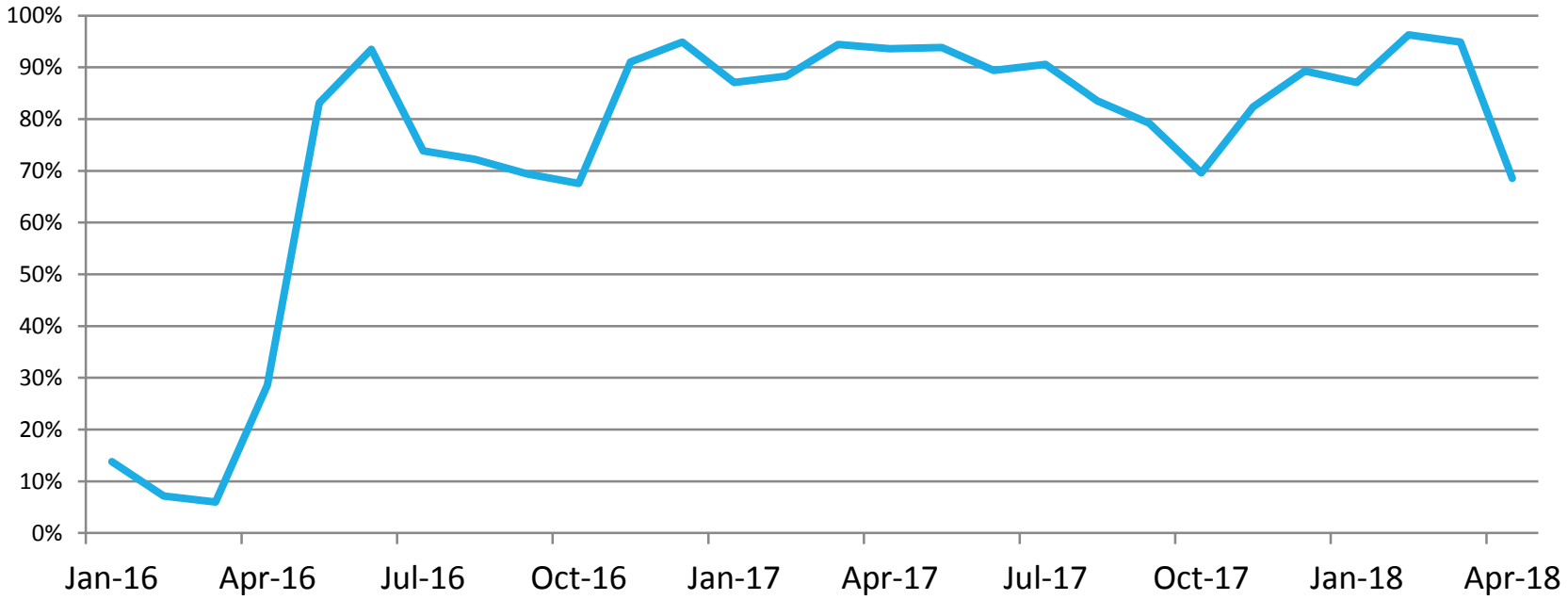
Know the Signs Outreach

Youth Health Navigation Post Crisis Visit in the ED

TFHD Policy: Behavioral Health Assistance in Outpatient Clinics, DTMSC 1602

Mental and Behavioral Health: Increasing Screening PHQ-9 Medicare Annual Wellness Visit

Percentage of Medicare Patients Screened during an Annual Wellness Visit for Depression Using the PHQ9 (all questions answered)

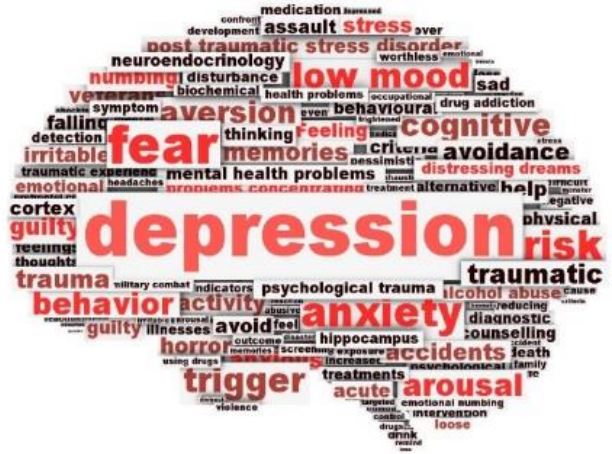


Mental and Behavioral Health: Increasing Screening PRIME PHQ-9 Medi-Cal (18+)

Implemented workflow processes (EHR)

- Screening Tools

PRIME Metric (Medi-Cal Only)	2016	2017	2018 (Jan-Apr)
Screening for Clinical Depression (PHQ-9)	5%	19%	36%



Mental and Behavioral Health: Reduce Suicide
Suicide Prevention Coalition

Events

- Know the Signs (multiple events)
- Giving Voice (North Tahoe High students)
- Giving Voice (Truckee High students & community)
- A Beautiful Mind (Movie)
- Coalition Community Meetings
- Gratitude (Mental Health in the Mountains)
- Gut Health (Mental Health in the Mountains)
- Suicide: A Complicated Grief (Mental Health in the Mountains)
- I have Tourette's and I have Social Anxiety (Movie)
- No One Cares About Crazy People (Book Club)

	Number of Events/Articles	Attendance/ Outreach
Outreach Events	28	1,394
Newspaper Articles	11	Region-wide

GIVING VOICE DOCUMENTARY LINK

Mental and Behavioral Health – Increase Access Gateway and PMAD Counseling

Gateway Mountain Center

Youth Therapeutic Mentoring Program

- Provided 933 hours of service for a total unreimbursed cost of $87,702
- TFHD Supported 106 hours
  - For the 2017 fiscal year, Gateway served 12 youth and transitional age youth

Gateway Mountain Center
Helping Youth
Learn, Heal & Thrive!

PMAD counseling

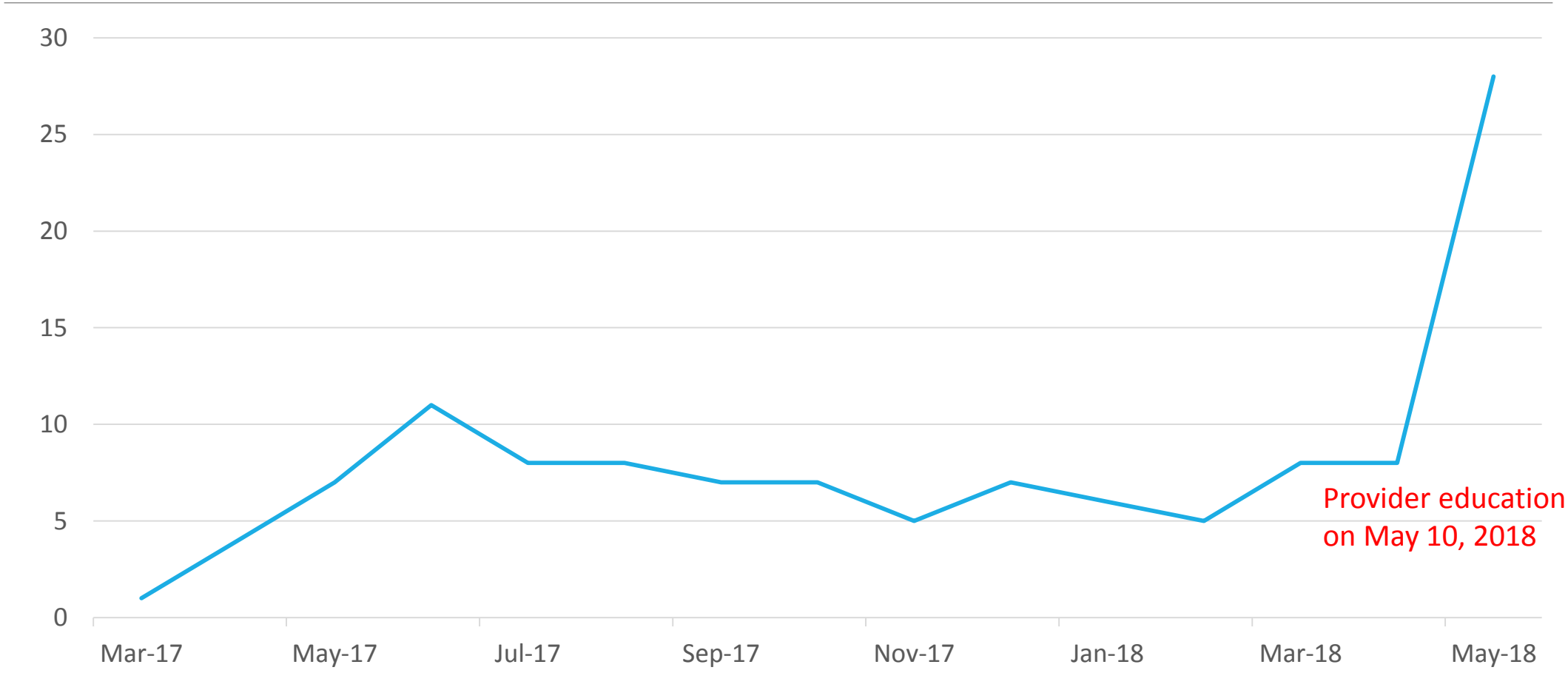
Edinburgh screening of all Prenatal patients 2-6 weeks post partum

29 referrals to counselling services since Aug 2017

- 22 (76%) Actively Engaged

Results: Patients express gratitude and relief at the ease of access to receiving expedient services locally. They appreciate the dialogue and coordination of care between the counselor, perinatal care coordinator and OB/GYN.

Mental and Behavioral Health – Increase Access
EPIC Referrals to Social Services



Mental and Behavioral Health

CHNA Indicator	2011	2014	2017	BRFSS CA, NV
Gets needed social and emotional support	93.1	86.9	90.1	***
One or more days with depressive symptoms in past 2 wks	***	***	57.0	***
At least one day mental health not good in past month	31.9	31.8	34.0	***
Any depressive symptoms	***	***	21.0	***
Stressed about paying rent/mortgage	19.3	***	15.5	***
Ever told has a depressive disorder	***	***	13.4	13.5, 17.2
Ever told has an anxiety disorder	***	***	10.4	***
Poor mental health days (mean)	3.1	3.0	2.1	3.6,3.9
PHQ-8 current depression indicator: currently depressed	***	***	4.5	***

Depressive symptoms (PHQ8): little interest, felt down, trouble with sleep, little energy, poor appetite or eaten too much, felt bad about yourself, trouble concentrating, changes in behavior typical to the individual.

Top 4 Health Needs Identified in the CHNA

- Nutrition and Exercise
- Chronic Disease Management
- Binge Drinking/Substance Use
- Mental Health

What have we learned?

Maintain

- Prevention and Optimize health – upstream approach

Increase

- Substance Misuse
- Mental and Behavioral Health

Transition

- Access to Care

Re-evaluate Community Financial Support

- Adjust funding based on priorities

Next Steps

Share CHNA with Community Collaborative Partners - June 5th

Develop Community Health Improvement Plan (CHIP) – June to August 2018

- Community Prioritization of Health Needs
- Magnitude
- Impact/Seriousness
- Feasibility
- Consequence of Inaction

Present CHIP to Board and seek approval of plan - September 2018

Components of CHIP

Strategic areas

Goals

Objectives

Performance measures - including base line and goal for improvement

Questions?

WELLNESS NEIGHBORHOOD

IMPACT ON BOARD INITIATIVES – 2011-2017

PRESENTED: JUNE 4, 2018

TAHOE FOREST HEALTH SYSTEM

wellnessneighborhood

A Service of Tahoe Forest Health System

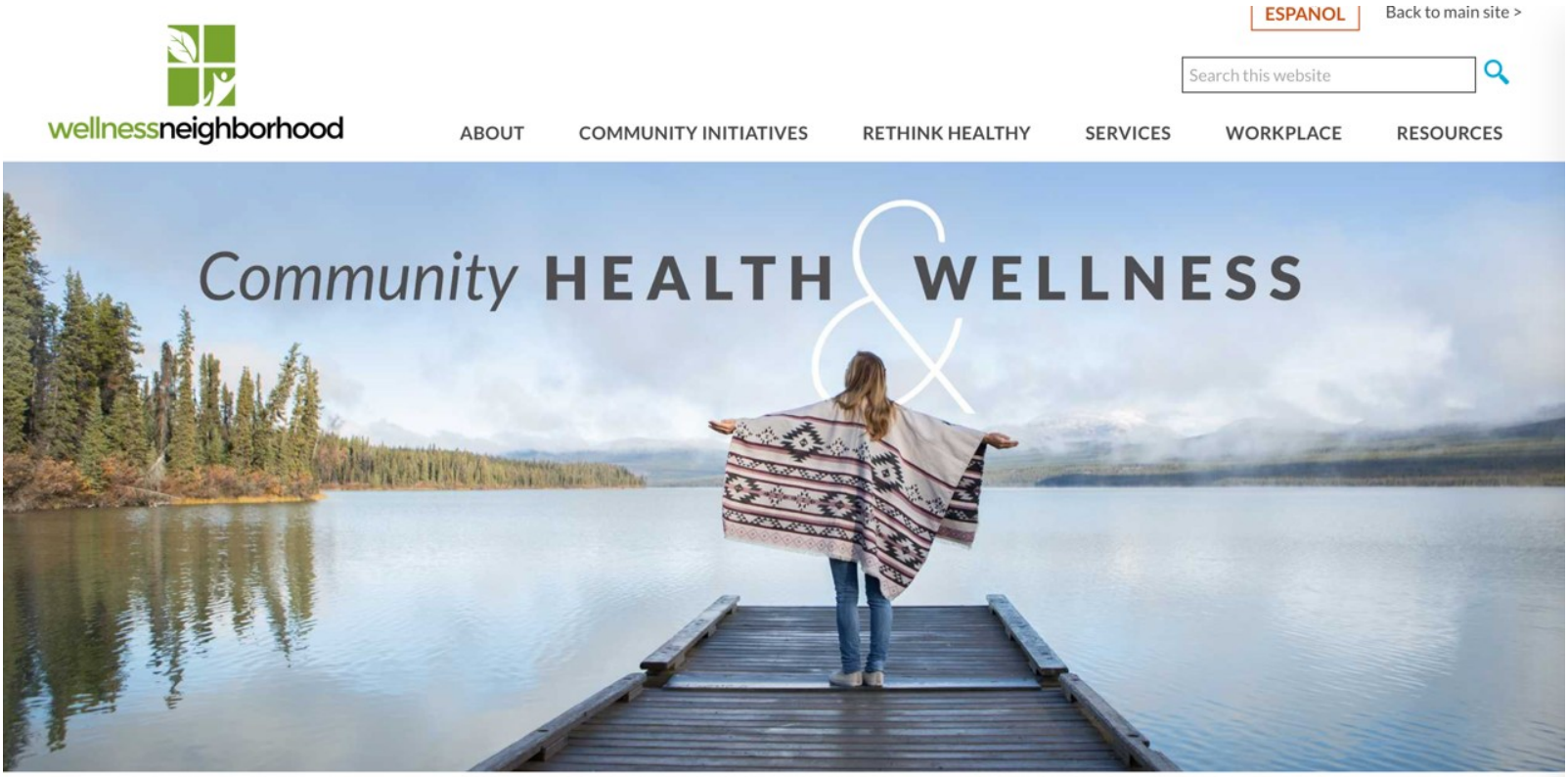
Community Health & Wellness Neighborhood and Care Coordination

2017 Annual Report

Collaboration *Integration* *Coordination*

Rethink Healthy!

The Wellness Neighborhood is a team of health professionals on a mission to educate, inspire and empower the Truckee/Tahoe community to improve their health through prevention, informed self-care, proactive medical care, chronic disease management , and lasting lifestyle change.



MANY THANKS TO OUR DEDICATED VOLUNTEERS!

Who helped with the employee produce program, dental education and screenings, self-management programs, chronic disease support group, and cooking matters classes.

- Sandra Dorst
- Bobbie Gifford
- Sherrie Pollock
- Alonzo Sanchez
- Hector Toledano
- Tessie Vulkovich
- Lynne Weakley

COMMUNITY PROGRAM SUPPORT:

In 20162017 we provided funding and in-kind support to the following innovative programs and organizations dedicated to meeting the needs of the Truckee/Tahoe community.

- North Tahoe Family Resource Center
- Family Resource Center of Truckee
- Gateway Mountain Center
- Tahoe Truckee Unified School District
- Tahoe Future Without Drug Dependence (TFWDD)
- Suicide Prevention Coalition

Supporting a Healthy, Thriving Community

Community Health, Wellness Neighborhood and Care Coordination embraced a year of change and new possibilities! Advances were made to integrate services , support timely and effective patient transitions of care, and implement collaborative community health and wellness services for a variety of target populations.

The primary focus was expanding our Care Coordination and Customer Care Navigation services to provide improved health outcomes and patient satisfaction.

New strategies to promote our services internally and in the community were implemented, including launching a new website - TahoeForestWellness.com – expanding promotions though social media, setting up a referral to wellness process in the electronic medical record, utilizing email and calendar outreach, and implementing monthly *Rethink Healthy* free community talks.

The result is increased physician referrals and an increased demand for health and wellness services.

There is more that we are ready to tackle and our team is primed for the challenge. Join us in helping to fulfill our mission of building a community culture of wellness and supporting our population in achieving their best health!

Wellness Neighborhood Staff

About the Wellness Neighborhood

The Wellness Neighborhood was established in 2012 to provide community health programming to meet the health priorities identified in the 2011 Community Health Needs Assessment.

Our current focus areas include:

- Optimizing Health and Primary/Preventive Health
- Access to Care and Care Coordination
- Mental and Behavioral Health
- Substance Misuse

The initiatives and outcomes presented in this document are intended to highlight CH/WN programming for population health management. These are not an exhaustive list of all CH/WN programs.

Optimize Health and Preventive Services

Achieve Your Best Health

Goal: Improve population health by decreasing disease specific mortality, reducing health disparities based on ethnicity, and promoting health supportive behaviors.

Spotlight: A Healthy Partnership

For over 10 years now, Tahoe Forest Health System has been partnering with the Tahoe Truckee Unified School District to make a positive impact in our schools and support healthy habits.

The Health System coordinates the very popular Harvest of the Month nutrition education and tasting program, provides guest lecturers to a variety of classes, assists in supporting the Athletic Trainer at the high schools, offers injury prevention programs, supports the Alcohol EDU prevention program, and provides the services of a Youth Health Navigator for students who have complicated medical concerns or are having trouble accessing health services.

One unique program the Wellness Neighborhood brought to TTUSD is B-Fit, a program that combines physical activity with life-long healthy behaviors. B-Fit was created to increase physical activity, prevent and reduce childhood obesity and improve academic performance in elementary school classrooms.

B-Fit incorporates daily activity bursts in the classroom along with monthly wellness themes. Teachers implement the activity bursts within the school day as a quick brain break and energy release which supports focus and concentration in class.

BFIT™

Growing Healthy Students Harvest of the Month

We envision a community where all children have access to regular, preventive and therapeutic dental services and oral health education to support healthy dental habits and optimal health.

Spotlight: Dental Coalition

Early childhood dental cavities are the most common chronic childhood health condition. Untreated cavities can lead to pain, missed school, emergency department visits, hospitalizations, and even death.

The Truckee/Tahoe Dental Coalition formed to address the oral health needs of children in our community. Our evidence-based framework consists of 3 primary strategies:

1. Outreach and education focusing on young children and their parents
2. Engage pediatric medical providers to apply fluoride varnish during Well-Child visits
3. Implement place-based education, fluoride varnish application, and screenings (in schools, child care centers, etc)

In April and May of 2017 we were able to reach 108 children and parents.

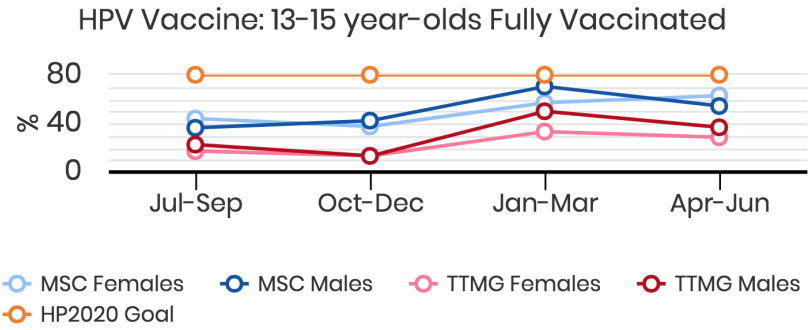
Expansion of school–based education and screenings are planned for the 2017-2018 school year.

Wellness Neighborhood FY17

Optimizing Health & Preventive Health Services

The Key to Cancer Prevention:

Direct Provider Outreach & Education to MSC and TTMG- An effective recommendation from Health Care Providers is the main reason parents decide to vaccinate.



Prevention Highlights

Truckee Air Show: Who is your hero?

Local Outreach

The Wellness Neighborhood provides outreach and education at local events to share important prevention resources and cultivate a culture of health in our community: 9,895 individuals reached through 1277 events/classes.

Breastfeeding

365 women participated in the weekly **Breastfeeding Support Group**

Injury Prevention

860 student athletes received **Athletic Training Services**

Affordable Lab

503 people participated in **Affordable Lab** events in Truckee and Incline

Walking

219 active participants walked 67,642,671 steps in our **Community Walking Challenges**

Community Wellness Challenges

- Walking (219 people)
- Project Zero (27 people)
- Gratitude (TFHD Employees)
- Fit in 10 (107 people)
- Hydration (53 people)

This year we implemented new challenges through the Blue Life App. Community Challenges engage people in becoming happier, healthier, and more energetic. The supportive group environment can help people adopt, and hopefully maintain, healthy new habits.

"After 1 week of increasing my water intake I feel much better overall. I have noticed that I am not eating so much between meals, and my energy has increased."

- Hydration Challenge Participant

Rethink Healthy Talks

November	January	February	March	April	May
Athlete For Life	Empowered Choices	Stop Counting Sheep	Intuitive Eating	Cancer Prevention	Internet Safety for Kids

Access to Care and Care Coordination:

Inform, Consult, Involve, Collaborate, Empower

Goal: Reduce per capita cost of health care by reducing unnecessary ED visits and readmissions. Improve population health by decreasing disease-specific mortality, reducing health disparities based on ethnicity, and increasing medical home enrollment.

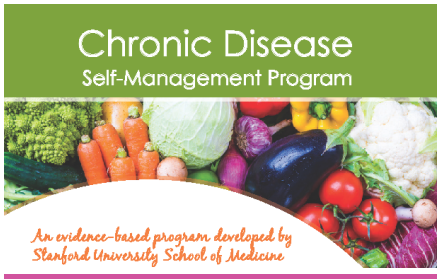
Spotlight: Care Coordination

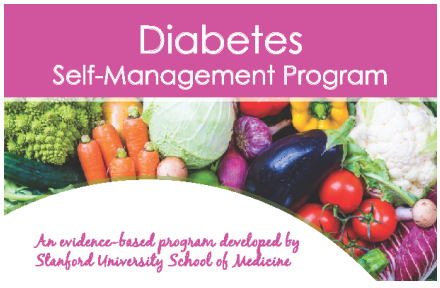
This year we saw a dramatic expansion in care coordination services which provides a new level of care and oversight for our patients. Care Coordinators ensure that high-need patients receive close follow-up and support so that they experience optimal health outcomes.

The Care Coordination team includes bilingual Health Promotoras who help Spanish-speaking patients with chronic disease and their families safely navigate the health system.

Many TFHD Care Coordinators are also certified health coaches. Health coaching utilizes communication methods to help patients increase their personal motivation for behavior change. The Care Coordinator and patient collaborate to identify a goal and talk monthly to track progress and reassess the strategies the patient wants to implement to improve their health.

IMPACT OF OUR HEALTH PROMOTORA:
Patient's Hemoglobin A1c Decreased from 11.7 TO 7.7!





Spotlight: Self-Management Programs

We offer three evidence- based self-management programs for people with chronic health conditions in partnership with the North Tahoe and Truckee Family Resource Centers. These 6-week classes are offered in English and Spanish, are free to the public ,and reach communities in Truckee, North Tahoe and Incline Village.

The classes are highly interactive and focus on building skill, sharing experiences, and peer support.

Participants who complete a self-management program report greater energy and reduced fatigue, improved health status, and greater confidence in managing their conditions.

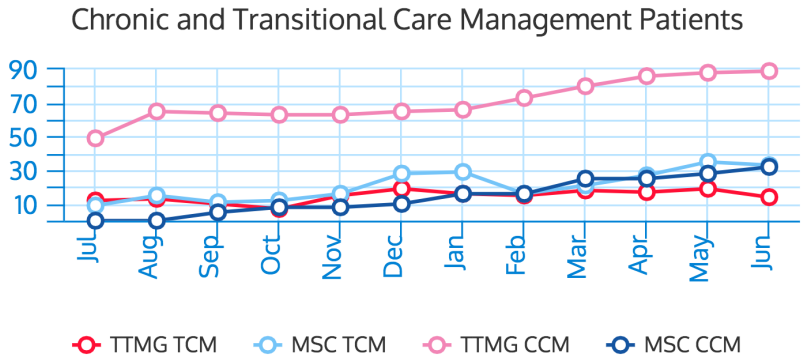
Wellness Neighborhood FY17

Access to Care & Care Coordination

Patients Coordinated:

688 unique patients received care coordination through:
-Transitional Care Mgmt
-Chronic Care Mgmt
-Youth Care Mgmt &
-Orthopedic Care Coordination

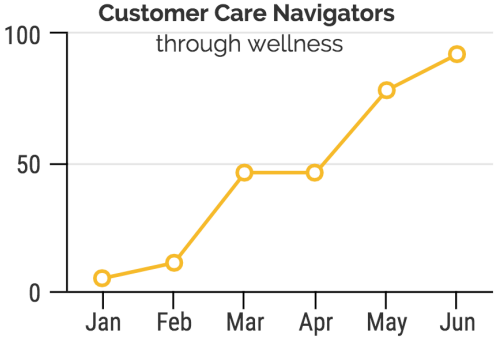
PRIME Programs:
-Million Hearts Care Coordination
-Chronic Pain Care Coordination



Supporting Our Patients

CCN

278 patients navigated by **Customer Care Navigators** through wellness



TCM

431 patients in **Transitional Care Management**

CCM

112 Medicare patients enrolled in **Chronic Care Management**

OCC

90 patients received **Orthopedic Care Coordination** for total joint replacement (in 3.5 months)

YCM

55 medically-complex youth navigated in **Youth Care Management**

Self Management

111 patients completed a 6-wk **Self Management** series

Successful Launch!!!

Each Care Coordination program took several months to develop. The time and energy put into infrastructure building and implementation resulted in a high demand for care coordination services and immediate provider referrals following launch.

"You literally took me by the hand from beginning to end, addressing all my needs, physical, mental, emotional. Your kindness, support, care, and professionalism was encouraging and comforting- You never let me give up on myself!" - Mrs. M (Orthopedic Patient)

Care Coordination Programs Currently in Development

Perinatal Lactation

Wound Care

Behavioral Health

Palliative Care

Mental and Behavioral Health:

Goal: Increase screening and identification of mental health needs and access to mental health care. Reduce disparities in access to mental health. Reduce suicide rate in our community.

Spotlight: Depression Screening in Primary Care

Primary Care providers are the backbone of our health delivery system and are playing a greater role in identifying those experiencing mental health concerns. One strategy for reaching this vulnerable population is though regular screenings for depression.

This past year, all MSC Providers participated in training to implement depression screening and screening for substance use (SBIRT-Screening and Brief Intervention and Referral to Treatment).

All positive screens are referred to our behavioral health coordinator for follow-up and connection to resources.

Depression Screening:

- **Pediatrics:** all patients ages 12+ are screened at Well Child Visits
- **Medicare:** all patients are screening during the Annual Wellness Visit
- **Medi-Cal:** all patients are screened annually (not necessarily at a Well Visit)
- **Perinatal:** all women are screened during pregnancy and at 6 weeks postpartum

Rx Drug
SAFE DISPOSAL PROJECT

Reduce Substance Misuse

Goal: Reduce substance abuse in the community and reduce the normalization of drug use community-wide with a specific emphasis on school-aged children. Educate population on dangers of alcohol, prescription and recreational drug abuse.

MBRP for Smoking Cessation

12 patients enrolled:

- 6 have quit
- 5 are in process , and have reduced smoking by half

Spotlight: Mindfulness Based Relapse Prevention (MBRP)

Our Psychologist, a member of the PRIME Chronic Pain and Million Hearts team, completed training in MBRP, a treatment approach developed at the Mindfulness Center at the University of California at San Diego, for individuals in recovery from addictive behaviors.

This treatment integrates mindfulness meditation with standard relapse prevention practices based in various cognitive-behavioral therapies to help prevent relapse in patients suffering from addictive disorders. For patients with severe addictive behaviors, medication assisted therapy is being provided so that medical models and psychological models are combined for increased success and safety.

Patients develop an awareness of their personal triggers and habitual reactions, and learn ways to create a pause in this seemingly automatic process. The process helps patients change their relationship to discomfort so they can respond to challenging emotional and physical experiences in skillful ways.

In addition to using this approach with addictive behaviors, MBRP has also been incorporated in our Kick Nicotine program with impressive results.

" I am so grateful that this program is available." - a patient.

Wellness Neighborhood FY17

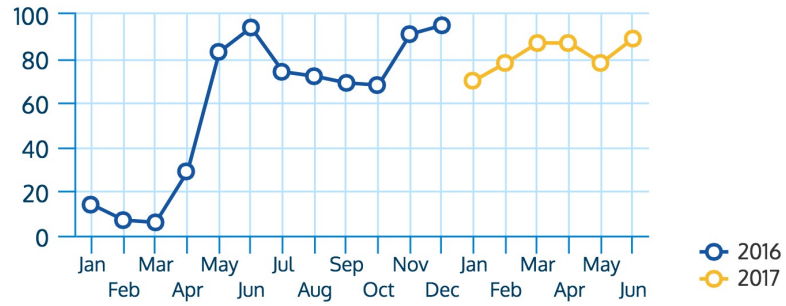
Mental & Behavioral Health/Substance Misuse

Suicide Prevention

Collaboration with TTUSD, County and Community Collaborative Partners.

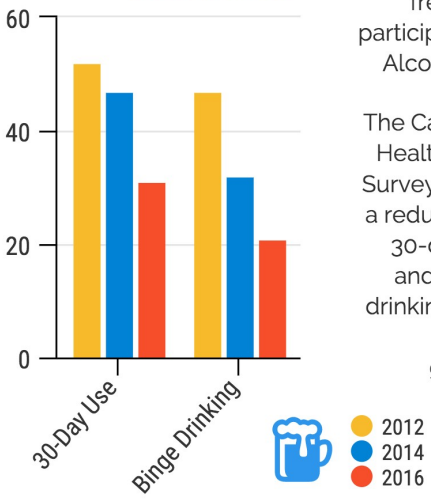
- Know the Signs
- Giving Voice Performance
- Community Book Club
- Postvention Protocol

Medicare AWV that included PHQ9 Depression Screening



Prevention Highlights

Alcohol Use



266 TTUSD freshman participated in AlcoholEDU.

The California Healthy Kids Survey shows a reduction in 30-day use and binge - drinking rates for 11th graders

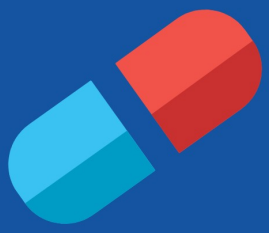
Stress Reduction

653 students reached in 17 classes for **Youth Stress Reduction**

Mentoring

106 hrs of therapeutic mentoring provided to youth by **Gateway Mtn Center**

Opioid Epidemic



Project ECHO

The UC Davis Project ECHO is a peer-to-peer, video conference, mentoring program designed to support community-based medical practitioners in their mission to provide high quality, safe and effective pain management. Multiple TFHS departments including Pharmacy, Primary Care, Emergency, Behavioral Health and Health Clinic providers participate weekly in this evidence-based resource to review case studies and learn innovative best practices.

Additional Outreach

- Annual Update of MH Resource Directory
- Pilot of Body Positive with TTUSD
- Initiation of Youth Crisis Follow Up
- Rx Take Back with TTFWDD
- Community Marijuana Workshops
- SBIRT Training with all MSC Providers

For More Information, check out our website at TahoeForestWellness.com
or contact us at: 530-550-6730