2025-2027 IMPLEMENTATION STRATEGY

Barton Health

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IDENTIFYING SIGNIFICANT HEALTH NEEDS

ABOUT BARTON HEALTH

Serving the Lake Tahoe community's healthcare needs for over 60 years, Barton Healthcare System (Barton Health) is a 501(c)(3) community health system that includes Barton Memorial Hospital, consisting of 24-hour emergency care services, 63 patient beds, a skilled nursing facility with 48 resident beds, and 30 ambulatory outpatient offices to serve the health and medical needs of our patients, residents, employees, visitors, volunteers, and the community. Barton Health is a bi-state health system serving the greater Lake Tahoe region. Barton Health has approximately 277 affiliated physicians and a team of 933 employees providing quality health care services to residents and visitors. Barton Health provides exceptional care, regardless of an individual's ability to pay. 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.

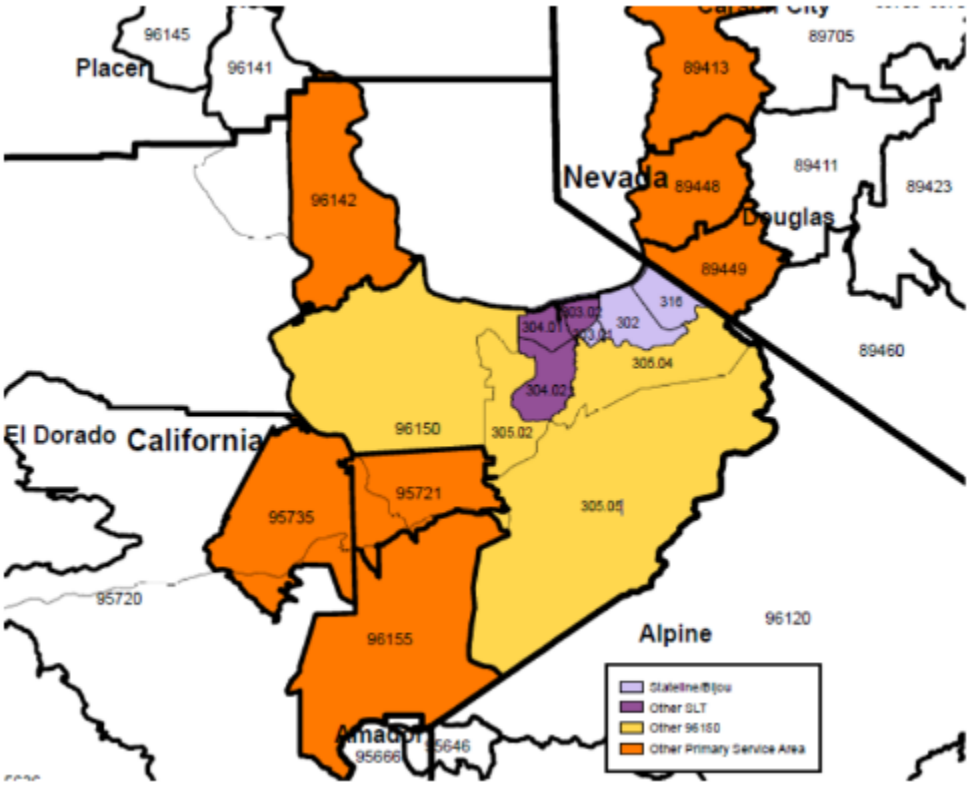
OUR COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA)

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

Definition of the Community Served

The study area for the survey effort is defined as each of the residential ZIP Codes comprising the Primary Service Area (PSA) of Barton Health, including 96150, 95735, 96142, 96155, 89413, 89448, 89449, 96151, and 96158. 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, Other South Lake Tahoe ("Other SLT"), Other 96150 ZIP Code ("Other 96150"), and Other Primary Service Area ("Other PSA").



How CHNA Data Were Obtained

The CHNA incorporated data about the community from multiple sources, including both primary and secondary data:

- A population-based survey among a representative sample of community residents (the PRC Community Health Survey)
- An online survey of public health representatives, health providers, and a variety of other community service providers and stakeholders (the PRC Online Key Informant Survey)
- A review of existing vital statistics, public health, census, and other data

The CHNA allowed for extensive comparison to benchmark data at the state and national levels.

The assessment was conducted on behalf of Barton Health by PRC, a nationally recognized health care consulting firm with extensive experience conducting Community Health Needs Assessments in hundreds of communities across the United States since 1994.

Identifying & Prioritizing Health Needs

Areas of Opportunity

Significant health needs (or "Areas of Opportunity") were determined in our CHNA after consideration of various criteria, including: standing in comparison with benchmark data; identified trends; the preponderance of significant findings within topic areas; the magnitude of the issue in terms of the number of persons affected; and the potential health impact of a given issue.

Prioritized List of Health Needs

After reviewing the Community Health Needs Assessment findings, internal team members and community stakeholders met to evaluate and prioritize the top health needs for our community. The participants were asked to evaluate each health issue along two criteria: 1) scope and severity of the health issue; and 2) the hospital's/community's ability to impact that issue. Individual ratings for each criterion were averaged for each tested health issue, and then these composite criteria scores were averaged to produce an overall score. This process yielded the following prioritized list of health needs for our community:

1. Mental Health
2. Substance Use
3. Access to Health Care Services
4. Tobacco Use
5. Cancer
6. Nutrition, Physical Activity & Weight
7. Heart Disease & Stroke
8. Infant Health & Family Planning
9. Respiratory Disease

ADDRESSING THE SIGNIFICANT HEALTH NEEDS

HOSPITAL-LEVEL COMMUNITY BENEFIT PLANNING

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/or 3) promoting an understanding of these health needs among other community organizations and within the public itself.

Priority Health Issues to Be Addressed

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

- Access to Health Care Services
- Mental Health
- Substance Use
- Heart Disease & Stroke
- Cancer
- Tobacco Use
- Nutrition, Physical Activity & Weight
- Infant Health & Family Planning
- Respiratory Disease

2025-2027 Implementation Strategy

Action Plans

The following displays an outline of Barton Health's plans to address those priority health issues chosen for action in the FY2025-FY2027 period.

Priority Area #1: Access to Healthcare Services	
Community Health Need	Improve access to primary and specialty care providers.
Goal(s)	1. Expand specialty and primary care services. 2. Identify and remove real and perceived barriers to receiving care. 3. Continue our development of community-based approaches for our most vulnerable community members focusing on meeting them where they are at.
Action Plan	**Strategy 1: Expand specialty and primary care services.** • Create a recruitment and retainment program to meet the needs of our community. • Implement best practices to continue to improve clinic efficiency, provider and staff satisfaction, and patient experience. • Consider community-based social determinants of health that can negatively affect access to care. **Strategy 2: Identify and remove real and perceived barriers to receiving care.** • Partner with community organizations to reduce healthcare disparities and meet the needs of people challenged to access appropriate care for their needs. • Promote neighborhood healthcare access and a model of clinical-community partnership. **Strategy 3: Continue our development of community-based approaches for our most vulnerable community members focusing on meeting them where they are at.** • Implement community outreach initiatives focusing on our most vulnerable community members. • Provide listen and learn opportunities for our LatinX partners and the community that they serve.
Anticipated Impact	Increased access to health care and supportive services and reduced barriers to care. Improved approaches to provide care to vulnerable populations. Increased patient satisfaction. Overcome social determinants of health barriers (geography, transportation, housing, etc) to improve access to specialized care.

Priority Area #2: Mental Health	
Community Health Need	Increased access to and availability of coordinated mental health services in our community.
Goal(s)	1. Increase mental and behavioral health capacity and improve coordination among behavioral health providers and community-based organizations. 2. Collaborate with local partners to build community capacity and create a “no wrong door” approach. 3. Reduce mental and behavioral health stigma through continued educational opportunities.
Partnering Organization(s)	El Dorado County Behavioral Health, El Dorado Community Health Centers, Lake Tahoe Unified School District, Tahoe Youth & Family Services, South Lake Tahoe Family Resource Center, Live Violence Free, A Balanced Life, First 5 El Dorado, and South Tahoe Alternative Collaborative Services.
Action Plan	**Strategy 1: Increase mental and behavioral health capacity and improve coordination among behavioral health providers and community-based organizations.** • Recruit additional behavioral health providers based on community need. • Develop advanced management pathways with our emergency department and community partners to create a “right care at the right time” model to decrease unintended ED visits. **Strategy 2: Collaborate with local partners to build community capacity and create a “no wrong door” approach.** • Streamline processes to link patients to the right level of care and service provider in the community. • Conduct an evaluation of current recruitment and retention practices for our system and community behavioral health providers to identify areas of opportunity and collaboration. **Strategy 3: Reduce mental and behavioral health stigma through continued educational opportunities.** • Work with community partners to develop interactive informational activities to decrease stigma and improve understanding of the importance of seeking appropriate care. • Implement community outreach and education focusing on our community’s most vulnerable.
Anticipated Impact	Improved access to mental health providers. Improved coordination of services throughout the entire care continuum. Understanding community partner needs in order to better collaborate and serve the community together. Reduced frequency of unintended/preventable emergency department visits. Increased awareness of treatment, reduced stigma, and improved early identification of mental health conditions.

Priority Area #3: Substance Use	
Community Health Need	Increased access to substance use and alcohol use disorder management and educational services
Goal(s)	1. Increase access to our Medication Assisted Treatment program. 2. Create a service line approach to expand access. 3. Participate in community-based committees, advisory boards, and community outreach activities related to substance use disorders.
Partnering Organization(s)	El Dorado County Health and Human Services, El Dorado County Substance Use Disorder Department, Lake Tahoe Unified School District, South Lake Tahoe Police Department, Tahoe Alliance for Safe Kids (TASK), RJ Counseling, El Dorado County Continuum of Care, and Mountain High Recovery Center
Action Plan	**Strategy 1: Increase access to our Medication Assisted Treatment program**. • Hire a new LCSW or peer support specialist, as well as maintain the Substance Use Navigator role to support the MOUD program. • Foster the development of bridge care between the healthcare system and community partners. **Strategy 2: Create a service line approach to expand access.** • Collaborate with community partners to expand opioid use disorder treatment services to include alcohol use disorder. **Strategy 3: Participate in community-based committees, advisory boards, and community outreach activities related to substance use disorders.** • Participate in the El Dorado County Community Health Improvement Plan Committee. • Participate in El Dorado County ACCEL and COPE steering committees.
Anticipated Impact	Reduced rates of substance use in our community. Increase access to substance use disorder treatments and education. Reduced frequency of unintended emergency department visits. Better awareness of local and regional initiatives related to managing opioid use disorder.

Priority Area #4: Heart Disease and Stroke	
Community Health Need	Education on the contributing factors leading to these diseases and providing expanded specialty care to address our community's need.
Goal(s)	1. Create a strategic plan to develop a cardiovascular and stroke service line. 2. Develop and/or expand clinical outreach services to educate around the causative factors of heart disease and stroke. 3. Partner with our rehabilitation department to determine opportunities to provide specialty services for this population.
Action Plan	**Strategy 1: Create a strategic plan to develop a cardiovascular service line.** • Develop a comprehensive service line. **Strategy 2: Develop and/or expand clinical outreach services to educate around the causative factors of heart disease and stroke.** • Align clinic teams to conduct screenings to identify patients with uncontrolled hypertension and provide appropriate follow-up and resources. • Create educational opportunities for our community to learn about the effects of high-cholesterol diets and ways to mitigate the likelihood of stroke. **Strategy 3: Partner with our rehabilitation department to determine opportunities to provide specialty services for this population.** • Develop a cardiac rehab program at our Stateline location. • Promote our TBI and neurological programs at our COE.
Anticipated Impact	Provide localized higher-level care for our community that will also address access issues. Create support services that help to minimize the stressors related to the treatment and recovery from these conditions. Decreased rates of heart disease and stroke.

Priority Area #5: Cancer	
Community Health Need	Leading-edge comprehensive local services from screening, to diagnosis, treatment, and recovery that focuses on meeting the patient's and their family members' needs.
Goal(s)	1. Create a strategic plan to develop a comprehensive cancer service line. 2. Educate our community on the benefits of early detection and best practices for effective treatment. 3. Provide specialty services and offerings for this population.
Action Plan	**Strategy 1: Create a strategic plan to develop a comprehensive cancer service line.** • Develop a comprehensive service line. **Strategy 2: Educate our community on the benefits of early detection and best practices for effective treatment.** • Education in community via articles, webinars, social media regarding importance of screenings **Strategy 3: Provide specialty services and offerings for this population.** • Expand the Exercise for Energy program for patients recovering from Cancer. • Offer enhanced mammograms and medical imaging technology. • Provide women's Health Screening Clinic held annually.
Anticipated Impact	Provide localized higher-level care for our community that will also address access issues. Create support services that help to minimize the stressors related to the treatment and recovery from a cancer diagnosis. Increased cancer screening rates and improved follow-up rates.

Proposed Activities to Address Remaining Priorities	
Tobacco Use	● Providers to continue high school presentations on the risks of vaping. ● Vaping presentations to service clubs and PTA/Cafecitos. ● Continue prioritizing vaping as a wellness lecture topic, targeting youth and parents. ● Support Drug Store Project by providing clinical experts.
Nutrition, Physical Activity & Weight	● Promotion of healthy nutrition CalFresh and the school district. ● Support local youth sporting events as well as community events that promote activity/wellness ● Community food distribution to underserved neighborhoods as well as assisting local pantries to obtain/purchase high quality proteins and fresh produce.
Infant Health & Family Planning	● Partner with the school health teachers and students advocate to provide education and resources on the importance of early prenatal care. Additionally, providing education that early prenatal care is an important and routine aspect of preconception care. Educate on the signs of pregnancy, and where to access affordable diagnostic testing to confirm pregnancy early in the gestation ● Work with community partners- First 5 El Dorado, Catalyst Community, Tahoe Youth & Family-- to provide support and resources. ● BCHC and Barton Women's Health's scheduling staff to expedite/prioritize the initial visit to ensure first trimester prenatal care
Respiratory Disease	● Develop and implement a rehab program to address impairments in muscle strength, heart and lung capacity, pain, balance, endurance, and walking ability. ● Develop adult and pediatric asthma outreach in collaboration with our respiratory department.

Implementation Strategy Adoption

On November 21, 2024, the Board of Barton Health approved this Implementation Strategy to undertake the outlined measures to better address the significant health needs of the community.

Signature

Chair, Board of Directors
Title

November 21, 2024
Date

This Implementation Strategy document is posted on www.BartonHealth.org