Marshall Medical
Annual Report and Plan for Community Benefit
November 1, 2022 – October 31, 2023

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Department of Health Care Assessment and Information (HCAI)
Accounting and Reporting Systems Section
Sacramento, California

MARSHALL

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About Marshall

Marshall is an independent, nonprofit community health care provider located in the heart of the Sierra Foothills between Sacramento and South Lake Tahoe. Marshall includes Marshall Hospital, a fully accredited acute care facility with 111 beds located in Placerville, several outpatient facilities in Cameron Park, Placerville, El Dorado Hills and Georgetown, and many community health and education programs. Marshall has over 220 licensed practitioners and over 1,400 employees providing quality health care services to more than 180,000 residents of El Dorado County.

Founded 65 years ago through a community-driven campaign, today Marshall offers the same world-class care offered in large cities, the same pioneering clinical trials, and the same compassionate care. To best serve the future needs of El Dorado County, Marshall has offices and clinics in Placerville, Georgetown, Cameron Park, and El Dorado Hills, where a new two-story 49,000 square-foot facility will open this coming winter. The El Dorado Hills expansion is designed to address the needs of the growing population in the area by offering family medicine, orthopedics and sports medicine, physical therapy, and laboratory services close to home. Across the county in Georgetown, Marshall's Divide Wellness Center provides many of the same services to those in the remote, rural area who might not otherwise have access to care.

Health services at the Marshall Hospital and clinic campuses include:

- Birth Center
- Cancer Center
- Cardiac Rehabilitation
- Cardiac services
- Diagnostic imaging services
- Emergency Department/Level III Trauma Center
- Gynecology and Well-women services
- Intensive Care/Critical Care Unit
- Laboratory
- Orthopedic Surgery
- Outpatient Occupational Therapy
- Outpatient Physical Rehabilitation
- Outpatient Speech Therapy
- Outreach services to the homeless and other vulnerable populations
- Palliative Care
- Respiratory Care
- Surgery (outpatient and inpatient)
- Wound Care

Marshall Cancer Center

Marshall and UC Davis Health established an affiliation for cancer services in 2022 that allows Marshall patients access to the renowned UC Davis Comprehensive Cancer Center through the UC Davis Health Cancer Care Network. Under this affiliation, Marshall's oncologists work directly with the UC Davis Comprehensive Cancer Center team to design leading-edge diagnostic and treatment plans. With this relationship, the latest cancer clinical trials are now available to Marshall's patients.

Awards

Marshall was the recipient of several awards and accolades in 2023:

- *US News and World Report* ranks Marshall as High Performing in Stroke and Pneumonia.
- Joint Commission's Gold Seal of Approval for Accreditation, a symbol of a health care organization's commitment to providing safe and quality patient care and Advanced Certification as a Primary Stroke Center.
- American Heart Association's 2023 Get With the Guidelines®
    - Stroke Gold Plus with:
        - Target: Stroke Honor Role Elite
        - Target: Type 2 Diabetes Honor Role
    - Rural Stroke Bronze Award
- Ranked as one of the top 100 Rural Community Hospitals by Chartis Center for Rural Health.
- BETA Healthcare Group, the largest professional liability insurer of hospitals on the West Coast, determined Marshall met the requirements for Quest for Zero: Excellence in Obstetrics, for the fifth year in a row and Excellence in Emergency Department Obstetric care.
- American Association of Cardiovascular and Pulmonary Rehabilitation Certified Program.
- Cal Hospital Compare 2022/2023 Honor Rolls:
    - Maternity Honor Roll awarded for hitting a statewide target for low-risk C-sections
    - Opioid Care Honor Roll awarded for progress addressing the opioid epidemic
    - Patient Safety Honor Roll awarded for higher patient safety performance
- California Department of public Health Silver Award to Antimicrobial Stewardship Honor Roll and Healthcare Associated Infection Program.
- Since 2009, the American Diabetes Association has recognized the Diabetes and Nutrition Education program for diabetes self-management education and support.
- Accreditation by the Commission on Cancer (CoC), a quality initiative program of the American College of Surgeons (ACS), for comprehensive patient-centered cancer care.
- Designated Baby-Friendly Hospital® by the World Health Organization and UNICEF.

Vision, Mission, and Strategic Plan

Vision

Marshall's vision is encapsulated in its statement of "just cause", which has been adopted by the Marshall Board to reflect the Organization's core purpose and communicated widely to providers, staff and the community:

> "Marshall commits to creating a community where everyone can attain their highest desired state of health and well-being."

Mission

Marshall proudly serves the Western slope of El Dorado County. Our mission is to improve the health of our community and offer services of superior value and quality, centered on the goals and needs of our patients. We strive to deliver service that exceeds our patients' expectations.

In support of our mission, Marshall has implemented an organization-wide program, "Elevate the Marshall Experience" to enhance the way we work as a team to deliver exceptional service to our patients and the community.

Strategic Plan and Direction

Marshall's multi-year strategic plan emphasizes the achievement of top decile clinical, operating and financial performance, the alignment of medical group and enterprise vision, enhancing Marshall's presence and competitive position in Western El Dorado County, and the retention of our valuable workforce.

Governance

The Marshall Hospital Corporation was founded in 1956 and continues to operate as a nonprofit, public benefit corporation. Marshall is organized without any intention of monetary gain to any person, persons or corporation. Marshall uses its funds for upgrading programs, purchasing new equipment and developing medical services that provide for the healthcare needs of the community.

The Marshall Board of Directors is a volunteer group of community members who provide their time and experience to set policies, maintain Marshall's financial stability and make decisions that affect the future of the organization.

Board of Directors

George Nielsen, Chair
Sean Anderson, MD, Chief of Staff
Tom Cumpston, Secretary/Treasurer
Jon Haugaard, Vice Chair
Siri Nelson, Chief Executive Officer
Anna Blair, RN
Gerardo Galang, MD,
Andrea Howard
John R. Knight
Alexis Long, MD
Mike Pervis
Christeen Reeg
Kim Stoll
Brian Veerkamp

Caring for our Community

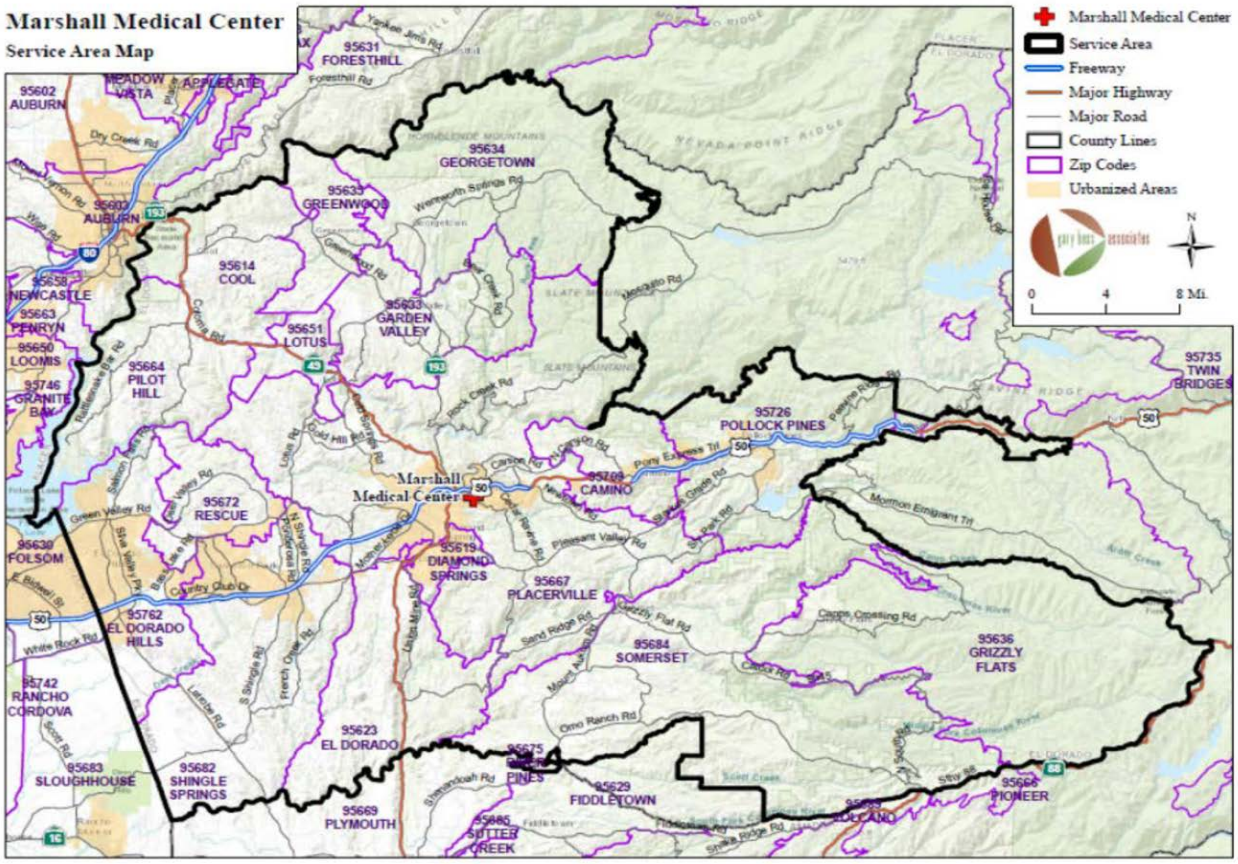
This report demonstrates tangible ways in which Marshall is fulfilling its mission to promote health improvement and provide health services to our community. In accordance with its Financial Assistance policy, Marshall supports those in the community who cannot afford services, or whose health insurance does not cover all services rendered. In addition, Marshall invests in the community to increase access to health care services and improve community health.

Service Area

Marshall Medical Center is located at 1100 Marshall Way, Placerville, California, 95667. The service area includes 17 ZIP Codes, representing cities or communities in El Dorado County and Amador County (River Pines). The Marshall Medical Center service area is presented below by community and ZIP Code and was determined from the ZIP Codes that reflect a majority of patient admissions from the local geographic area.

Marshall Medical Center Service Area

Geographic Areas	ZIP Codes
Camino/Apple Hill	95709
Cool	95614
Diamond Springs	95619
El Dorado Hills	95762
Garden Valley	95633
Georgetown	95634
Greenwood	95635
Grizzly Flats	95636
Kingsville/Nashville	95623
Lotus	95651
Pilot Hill	95664
Placerville	95667
Pollock Pines	95726
Rescue	95672
River Pines	95675
Shingle Springs/Cameron Park	95682
Somerset	95684



Community Snapshot

The population of the Marshall service area is 158,730. Children and youth, ages 0-17, are 20.6% of the service area population. 57.9% are adults, age 18-64, and 21.5% of the population are seniors, ages 65 and older. The service area has fewer children, youth and younger adults, and a higher percentage of residents, 45 years and older, than the state.

The largest portion of the population in the service area are White residents (80.1%). 10.6% of the population are Hispanic or Latino residents, 4.3% of the population are Asian residents, 0.8% of the population are Black or African American residents and the remaining 4.2% are American Indian or Alaskan Native residents, Native Hawaiian or Pacific Islander residents, or residents who are some other race, or multiple races.

Among the residents in the service area, 7.9% are at or below 100% of the federal poverty level (FPL). Educational attainment is a key driver of health, and in the hospital service area, 6.0% of adults, ages 25 and older, lack a high school diploma. *(Source: Marshall Medical Center 2022 Community Health Needs Assessment.)* 3.6% of the population in the service area lack health insurance. North El Dorado County and Pollock Pines are designated as Medically Underserved Areas for primary care *(Source: data.HRSA.gov.)*

Community Health Needs Assessment

Marshall Medical Center completed a Community Health Needs Assessment (CHNA) in FY22 as required by state and federal law. The CHNA is a primary tool used by Marshall to determine its community benefit plan, which outlines how it will give back to the community in the form of health care and other community services to address unmet community health needs.

The assessment incorporated components of primary data collection and secondary data analysis that focused on the health and social needs of the service area population. The CHNA examined up-to-date data sources for the service area to present community demographics, social determinants of health, health care access, birth indicators, leading causes of death, COVID-19, acute and chronic disease, health behaviors, mental health, substance use, and preventive practices. When applicable, these data sets were presented in the context of El Dorado County and California and compared to Healthy People 2030 objectives.

Targeted interviews were used to gather information and opinions from people who represented the broad interests of the community served by the medical center. Seventeen (17) interviews were conducted by phone in June 2022. Interviewees included leaders and/or representatives of medically underserved, low-income, and minority populations, local health or other departments or agencies that have current data or other information relevant to the health needs of the community. A survey was distributed to engage community residents. The survey was available in an electronic format and 62 surveys were collected from June 6 to July 11, 2022. The surveys engaged residents who were diverse in age, gender, race and ethnicity. Some survey residents lacked health insurance coverage, others delayed or went without needed health care services. Stakeholder interviews and community surveys identified vulnerable populations in the community who were the most affected by the significant health needs in the community.

Significant Health Needs

An analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs and discover gaps in resources. The identified significant needs included (in alphabetical order):

- Access to care
- Chronic diseases
- COVID-19
- Environmental conditions
- Food insecurity
- Housing and homelessness
- Mental health

- Overweight and obesity
- Preventive practices
- Substance use
- Unintentional injuries

The identified significant health needs were then prioritized with input from the community. The community stakeholders were asked to rank order the health needs according to highest level of importance in the community. Housing and homelessness, mental health, substance use, access to health care and chronic disease were ranked as the top five priority needs in the service area.

Within El Dorado County there are at least four organizations that undertake community health needs assessments, each use similar data sources, but undertake their needs assessment independently of each other. To better coordinate needs assessment and action across the County, discussions are underway to explore a shared approach to this process. One challenge is the difference cycle timelines each organization is currently following.

The complete CHNA report and the prioritized health needs can be accessed at: https://www.marshallmedical.org/about-us/community-benefit/. We welcome feedback on the Community Health Needs Assessment and Implementation Strategy. To send comments or questions, please contact Dr. Martin Entwistle at mentwistle@marshallmedical.org.

Addressing Priority Health Needs

In FY23, Marshall engaged in activities and programs that addressed the priority health needs identified in the FY23-FY25 Implementation Strategy. Marshall committed to community benefit efforts that addressed: behavioral health (included mental health and substance use), chronic disease prevention, management, and treatment, and support for the health and welfare of the community. Selected activities and programs that highlight the hospital's commitment to the community are detailed below.

Access to Behavioral Health Services (Mental Health and Substance Use)
Response to Need

Marshall CARES (Clinically Assisted Recovery & Education Services)

CARES was created to treat opiate use disorder, but it has grown into a clinic focused on support treatment for persons with any substance dependency, including alcohol, tobacco, stimulants, opioids, benzodiazepines, and other sedative hypnotics. Clinic services include comprehensive medication assisted treatment with a physician, counseling, case management and behavioral health support services.

Medication Assisted Treatment (MAT)

Since December 2016, Marshall has participated in a joint effort with the El Dorado Community Health Center (EDCHC) and the California Healthcare Foundation to provide Medication Assisted Treatment (MAT) for opioid addiction. When people present in Marshall's Emergency Department in withdrawal, they are offered participation in the MAT/ED Bridge program, which includes buprenorphine to alleviate withdrawal symptoms. Through the EDCHC and Marshall CARES, they are also referred to outpatient therapy, where they meet with a doctor within 48 hours. The program includes group sessions, counseling, and social services.

Chronic Disease Prevention, Management and Treatment
Response to Need

Population Health

The Marshall Population Health team coordinated the community case services that Marshall delivered, with the objective of strengthening the continuum of care provided to our patients and the community. Driven by primary care providers, and with engagement of clinic staff and specialists, Marshall placed particular focus on screenings for breast cancer, colon cancer and diabetes and met or exceeded its performance targets in all three areas.

Community Care Network (CCN)

The CCN focuses on improving the effectiveness and quality of care for high-risk patients. Marshall's CCN assists chronically ill patients with health care coordination and management, in-home care,

medical supplies, and volunteer health coaches, at no cost. CCN removes obstacles that often prevent people from receiving routine and preventive care as well as to prevent the potential need for rehospitalization. This program reduces readmissions and unnecessary emergency room visits. For persons with more complex needs, a team of social workers, LVNs, RN case managers, pharmacists, diabetes educators, dietitians, and physical therapists work with them in their homes to help navigate their paths to improved health and overcome community barriers.

Another CCN initiative is the Mobile Medicine and Rural Outreach program, which provided primary care, wound care, and women's health services in partnership with local organizations. Programs included:

- Mobile services reached homeless camps, cabins in the woods and the elderly in the comfort of their homes who were inhibited by a lack of transportation or other means and were challenged to meet the expectations of a traditional office visit.
- Clinical services were provided on library campuses throughout the county.
- Working with Upper Room, a local organization that supports the elderly, low income and unsheltered individuals, the outreach program provided wound care, supported medication adherence, took vital signs, provided referrals and health education, called providers with clients, established primary care appointments, scribing for health insurance coverage documents, and offered psychiatric support.

In FY23, 5,543 persons were reached through CCN.

Congestive Heart Active Telephone Treatment (CHATT)

The CHATT program helped people manage congestive heart failure. CHATT improved quality of life, reduced CHF complications and helped keep people with CHF out of the hospital. This service included frequent telephone calls from a registered nurse, who specializes in cardiovascular care. In FY23, CHATT served 335 individuals.

Cancer Resource Center

Marshall's Cancer Resource Center provided classes, support groups and services. Services were available to anyone impacted by cancer in El Dorado County.

- Transportation is a well-known barrier to health care, especially in rural areas. The Cancer Resource Center provided 23 round trip rides as well as provided 78 persons with gas cards.
- The Wig Bank served 44 people.
- Provided 53 no-cost mammograms.
- Provided lodging assistance for 2 people who could not afford the cost of a hotel room while obtaining cancer treatment.
- 50 people participated in a community wide Cancer Prevention Event.
- Worked in partnership with Images of Hope to provide a Pilates class and a knitting class for

people with cancer.

Health Education

In FY23, Marshall reached 496 community members with the following community health education sessions:

- Joint replacement education
- Alzheimer's and dementia education
- Weight Loss Management

Diabetes and Nutrition Education

Healthy Living classes were provided monthly to 116 people. These free virtual classes, led by a nurse, provided information on the basics of diabetes self-management. Classes included: Understanding Diabetes and Planning for Success and Healthy Eating for Diabetes.

In addition, Marshall provided tele-visits for the Diabetes in Pregnancy Program, a gestational diabetes program that reached 53 people. Participants learned about nutrition and meal planning, controlling blood sugar, exercise and emotional support resources.

Affair of the Heart

Health care professionals provided heart health information to 175 seniors at senior living and retirement communities.

Remote Patient Management for Rurally Isolated Individuals

Marshall, in partnership with UC Davis commenced a pilot program to identify approaches to overcoming challenges in the deployment of remote patient management devices to those living in rural communities, which include connectivity, fear of technology, desire to be completely independent. Our goal is to proactively identify needs and connect individuals to services in the community

Support Groups

Support groups were offered to community members through online options, including Zoom. The support groups included: stroke and prostate cancer.

Support for the Health and Welfare of the Community
Response to Need

Financial Aid and Health Insurance Assistance

Provided financial assistance through free and discounted care for health care services, consistent with Marshall Medical Center's financial assistance policy. Offered assistance to enroll in public health insurance programs.

Transportation and Other Medical Needs

Provided transportation to people who could not afford transportation to or from medical services and appointments. For persons living in poverty, the hospital provided medications and assisted living services. 450 people were served.

Community Health Library

Marshall's Community Health Library contains over 5,000 resources, which were made available at no charge for use by community residents. Staff librarians also conducted medical topic searches for community members. In FY23, 276 community members accessed these services.

Stop the Bleed

Marshall trained staff members as instructors to educate community members to treat injuries caused by home accidents, motor vehicle accidents, active shooters, bombings, and work-related injuries. In FY23, Marshall staff instructors trained 120 El Dorado County residents, including students and teachers at local schools on wound packing and tourniquet application.

Fall Prevention

Provided the Matter of Balance fall prevention class that engaged five community members.

Community Health Magazine

For Your HEALTH is Marshall's quarterly magazine, which was widely distributed throughout El Dorado County and available in digital format on the hospital's website. Topics in FY23 included: general wellness, vaccinations, and disease prevention.

Childbirth Classes

Provided free or low-cost educational classes to the community, including childbirth classes. Classes were self-paced and virtual and were paired with Livestream Q & A sessions. Class topics included: healthy pregnancy, breastfeeding, newborn baby and behavior, soothing techniques, bathing, health and safety skills, and nutrition. 103 community members participated in English and Spanish.

Other Community Benefit Services

Marshall Medical Center provided community benefit services in addition to those programs focused on addressing priority health needs.

Health Professions Education

Definition: education programs for physicians, nurses, nursing students, and other health professionals.

Nursing

A total of 61 Registered Nurse students and 12 Nurse Practitioners received precepted training. Marshall participates as a clinical setting for the Rural California Nursing Preceptorship (RCNP) Program. RNCP is designed to give student nurses and graduate nurses (RNs) an opportunity to gain clinical experience in a rural or semi-rural setting.

Other Health Professions

Marshall served as a health education training site for:

- 3 Pharmacy students
- 6 Radiology Technicians
- 9 Respiratory Therapists
- 2 Clinical Lab Technicians
- 2 Phlebotomists
- 26 Paramedic students

In 2023, Marshall began serving as a clinical rotation site for physician assistants from Stockton's University of the Pacific. In 2023, 4 physician assistants received clinical precepting.

Five scholarships for health professions education were provided to high school students pursuing a career in the health professions.

Cash and In-Kind Donations

Definition: funds and in-kind services donated to community groups and nonprofit organizations.

- Monetary contributions were made to nonprofit organizations that support community benefit efforts and address significant health needs in the community.
- Members of the leadership team contributed time and expertise to local and regional agencies that focused on health improvement and addressing the social determinates of health. Notably, Marshall employees participated in the following organizations, agencies and activities (partial list):
    - American Hospital Association
    - Breastfeeding Coalition
    - California Association of Hospitals and Health Systems
    - California Hospital Association
    - El Dorado Community Health Clinic Board
    - El Dorado EMS Joint Powers Authority

Community Benefit Operations

Definition: direct and indirect costs associated with assigned staff, community health needs assessments, community benefit planning, tracking, reporting, evaluating and operations.

Reported costs included:

- Community benefit staff salary, benefits and expenses
- Administrative support for community benefit
- Community benefit consultants

Community Building Activities

Definition: activities that support community assets by offering the expertise and resources of the hospital organization. These activities may address the root causes of health problems or the determinants of health, such as education, homelessness, poverty and the environment.

Workforce Development

Marshall leadership participated in the El Dorado Union High School District Career Technical Education Advisory Committee, a group of private entities that assist the high school district plan and prepare for technical careers and education offerings. 45 students participated in the Health Career Exploration Days.

Advocacy

Hospital representatives engaged in advocacy efforts that supported the community.

Economic Development

Hospital leaders supported local Chambers of Commerce and focused on issues related to community health and safety.

Financial Summary of Community Benefit

Marshall's community benefit costs comply with Internal Revenue Service instructions for Form 990 Schedule H. Marshall provides financial assistance and community benefit services, programs and activities that serve children, adults and seniors. The costs of providing these services are not fully reimbursed. The Hospital's community benefit costs comply with Internal Revenue Service instructions for Form 990 Schedule H. Costs are calculated using the hospital's cost accounting system.

Community Benefit Categories	Net Benefit
Financial Assistance[1]	$2,489,482
Unpaid Costs of Medi-Cal[2]	$27,062,904
Costs of Other Means Tested Government Programs	$0
Education and Research[3]	$346,608
Other for the Broader Community[4]	$2,923,075
Total Community Benefit Provided Excluding Unpaid Costs of Medicare	**$32,822,069**
Unpaid Costs of Medicare[2]	$52,304,407
Total Quantifiable Community Benefit	**$85,126,476**

[1] Financial Assistance includes traditional charity care write-offs to eligible patients at reduced or no cost based on the individual patient's financial situation. Financial Assistance or Charity Care does not include costs for patients who had commercial insurance, but could not afford their out of pocket costs.
[2] Unpaid costs of public programs include the difference between costs to provide a service and the rate at which the hospital is reimbursed.
[3] Costs related to the health professions education programs and medical research that the hospital sponsors.
[4] Includes non-billed programs such as community health education, screenings, support groups, clinics, support services, and community benefit operations.

Community Benefit Plan FY24

Marshall continues to implement activities and programs to address the selected priority needs in our service area.

Significant Needs the Hospital Intends to Address

Marshall intends to take actions to address the following health needs that were identified in the FY22 CHNA and detailed in the FY23-FY25 Implementation Strategy:

- Behavioral health (including mental health and substance use)
- Chronic disease prevention, management, and treatment
- Support for the health and welfare of the community (including access to health care and housing and homelessness)

Behavioral Health (Including Mental Health and Substance Use)

Objective: Facilitate timely access to comprehensive, coordinated services for individuals with behavioral health needs, including mental health, substance use and other identified priorities.

Strategy One

Expand access to services that will impact mental health and behavioral health within El Dorado County

1. Strengthen partnerships with external entities, through consultation and coordinated services planning to target prevention and education and increase support for patients in primary care clinics and the emergency department.
2. Explore how to optimize the use of our behavioral health specialists, including, but not limited to, social workers and clinical psychiatrists.
3. Work to advance the management of persons presenting in the Emergency Department with a mental health crisis by partnering with El Dorado County Mental Health Services and law enforcement agencies and adopting best-practice models to care for this population.
4. Work with community partners to improve access to services for children, youth, and adults with lower acuity behavioral health needs, including counseling and community assistance programs, including exploring how services are structured and funded so that the delivery of services are optimized to make maximum use of the resources available.
5. Marshall will designate a representative to participate in El Dorado County's Community Health Improvement Plan teams(s) to address mental health issues within EDC, including collaborations to enhance transitions of mental health care and expand services to address areas of identified need.
6. Explore the use of telehealth services to increase access to mental, behavioral, and substance use services, and for crisis care and ongoing care.

Strategy Two

Reduce and prevent substance use within El Dorado County.

1. Marshall will expand access to substance use management through Marshall CARES (Clinically Assisted Recovery & Education Services) and its ED Bridge Program to support treatment for persons with substance dependency and coordinate its approach with other agencies in the establishment and maintenance of care.
2. Marshall will build on models it has implemented to support the management of Opioid Use Disorder, to additionally support Alcohol Use Disorder, and those challenged with addictions to methamphetamines and tranquilizers.
3. Partner with community providers to actively work to facilitate access to substance use services in rural areas, in particular those with higher needs, and to support programs that target harm reduction, the removal of stigma, prevention and education, including families and education in schools, with a focus on middle schools and high schools.
4. Evolve the use of Substance Use Navigators (SUNs) to bridge care among emergency departments, clinics, the hospital and the community with the objective of increasing the numbers available to increase access and support the sustained engagement of persons in substance use management programs.
5. Strengthen partnerships with external entities, including El Dorado County Health and Human Services, El Dorado County Behavioral Health, El Dorado Community Health Centers, and the Shingle Springs Health and Wellness Center, through consultation and coordinated services planning in order to expand capacity to provide substance use prevention and treatment services, fill gaps in care and advance education.
6. Designate a representative to participate in El Dorado County's Community Health Improvement Plan team(s) to address access to substance use prevention and treatment programs within El Dorado County, and in the El Dorado County Opioid Coalition.
7. Work with other providers and agencies to improve the coordination of substance use care and behavioral health care and to include a focus on transitions from jail/hospital/street to home, street, and those experiencing homelessness.

Chronic Disease Prevention, Management and Treatment

Objective: Reduce the impact of chronic diseases on health and increase the focus on chronic disease prevention and treatment.

Strategy One

Prioritize capacity and utilization of disease prevention, management and treatment services.

1. Advance support for population health management to optimize the health and wellbeing of our community through sustainable programs that promote health and will partner with other providers to coordinate program delivery and care.
2. Expand preventive care and care management programs, in particular those identified to

prevent chronic or debilitating conditions and promote health and wellbeing and continue to advance standardized best practices for identified disease management and treatment services and programs.

3. Recruit providers to fill gaps in needed services, including physicians, advanced practice nurses and physician assistants. And work with partners in the community to coordinate the delivery of medical services between provider organizations.
4. Support collaborative disease prevention and health education efforts within the community, including, but not limited to, women's health events, youth programs, services for seniors and local community task forces.
5. Implement tools that support its mission for population health, including data collection analysis and reporting, health prevention and maintenance, in particular where these will assist in the coordinated delivery of care, track outcomes, support public health initiatives and improve performance.

Strategy Two

Provide for an improved continuum of care through care coordination, transitions of care between community and hospital, and communications among the providers serving the community.

1. Actively work with partners in the community to coordinate the care we deliver collectively, fill in gaps in care and improve coordination of services through collaboration and innovation.
2. Marshall will work to support residents living healthy lives in the community, improve transitions of care from the hospital, improve management of admissions and readmissions, improve connections to primary care, and increase access to social and disability support.
3. Work actively with partners to implement community-wide strategies for the homeless, taking into account their health, social and behavioral needs, and making sustainable changes to the health and welfare outcomes for the homeless population.
4. Work with partners in the community to support the older population by improving access to care and the coordination of service delivery, to reduce isolation and support seniors to be healthy and live safely at home.
5. Work to increase access to Advanced Illness Management services to assist persons with complex or life-limiting conditions be more aware of their conditions and make optimal health choices.
6. Work with community partners to develop collaborative systems that share information to better coordinate service delivery for those in need, prevent individuals falling through gaps in care, and track and report progress and performance.
7. Work with community partners to improve access to organized resources detailing the availability of services and accessible by the public and first responders, care givers, teachers, churches, and interested community members.

Support for the Health and Welfare of our Community

Objective: Actively partner to remove identified barriers that impact health and wellness, access to services, and transitions in care.

Strategy One

Identify and coordinate activities that positively impact persons with higher health needs.

1. Partner with community organizations to reduce healthcare disparities and meet the needs of persons challenged to access appropriate care for their needs; in particular those with mental health issues, substance use issues, ethnic minority groups, those of lower socioeconomic status and the homeless.
2. Partner with community leaders and organizations that can secure resources and the commitment to drive positive change for those with more severe health needs.
3. Partner with others in the community to better coordinate delivery of services, access to care and support for the older population with the objective of addressing isolation and supporting seniors to live healthy lives and remain safe at home.
4. Work with partners to support individuals to be healthy and live safely in the community. Targeted activities will include improving the coordination of service delivery, transitions of care and programs that support directly addressing social determinants of health that drive negative outcomes including housing and transportation.
5. Work with partners in the community to develop collaborative systems to share information to better coordinate service delivery to those in need, prevent individuals falling through gaps in care, and to track and report progress and performance.

Strategy Two

Increase access to programs that support prevention and health maintenance.

1. Work with partners in the community to establish a culture of prevention within El Dorado County and target outreach efforts to educate on the value and importance of preventive services, screenings, vaccination and wellness checks. There will be a particular emphasis on those residents who are at higher risk, including children, youth, young adults and seniors.
2. Support the development and/or expansion of care management services, including but not limited to the Community Care Network, vulnerable population outreach, substance use management programs and the Advanced Illness Management team in support of people living healthy lives in the community and reducing the avoidable need for acute care services.
3. Strengthen partnerships with external entities through consultation and coordinated services planning in order to expand external capacity to provide prevention and treatment services, fill gaps in care and advance education.
4. Provide training on diversity and equity that will cover stigmatized conditions such as mental and behavioral health, substance use, sexual orientation, age, socioeconomic status, weight management and homelessness.

Evaluation of Impact

Marshall monitors and evaluates key initiatives to access the programs and activities outlined in this Community Benefit Plan. We have implemented a system for the collection and documentation of tracking measures, such as the number of people reached or served, and collaborative efforts to address health needs. An evaluation of the impact of Marshall's actions to address these significant needs will be reported in the next scheduled CHHA.

Needs the Hospital Will Not Address

Since Marshall cannot directly address all the health needs present in the community, we will concentrate on those health needs that can most effectively be addressed given our areas of focus and expertise. With this in mind and taking existing medical center and community resources into consideration, Marshall will not directly address the remaining health needs identified in the CHNA, including COVID-19, environmental pollution, food insecurity, overweight and obesity, and unintentional injuries. Marshall will endeavor to address any prevalent or unanticipated issues that may threaten the health and wellbeing of the community.

Contact Information

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Community Benefit Contact
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