MARSHALL

Implementation Strategy

FY26 – FY28

APPROVED BY THE BOARD OF DIRECTORS IN FEBRUARY 2026

Table of Contents

Introduction

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, outpatient facilities in Cameron Park, Placerville, El Dorado Hills and Georgetown, and many community health and education programs. Marshall has over 190 affiliated physicians and providers, and over 1,600 employees providing quality health care services to more than 180,000 residents of El Dorado County.

Marshall conducted a Community Health Needs Assessment (CHNA) in 2025, which was adopted in August 2025. The CHNA complied with state and federal regulations guiding tax-exempt hospitals, assessing the significant health needs for the hospital's service area. The CHNA and Implementation Strategy help guide the hospital's community health improvement programs and community benefit activities, as well as its collaborative efforts with organizations that share a mission to improve health.

Purpose

California Senate Bill 697 and the Patient Protection and Affordable Care Act through IRS section 501(r)(3) regulations direct nonprofit hospitals to conduct a CHNA every three years and develop a three-year Implementation Strategy that responds to identified community needs. This Implementation Strategy details how Marshall plans to address the significant health needs identified in the 2025 CHNA. The hospital will build on previous CHNA efforts and existing initiatives, while also considering new strategies and efforts to improve health.

Report Adoption, Availability and Comments

This Implementation Strategy was adopted by the Board of Directors in February 2026. The CHNA and Implementation Strategy are available on the hospital's website at https://www.marshallmedical.org/about-us/community-benefit/. Public comment on the CHNA and Implementation Strategy is encouraged as community input is used to inform and influence this work. Written comments on this report can be submitted to Dr. Martin Entwistle at mentwistle@marshallmedical.org.

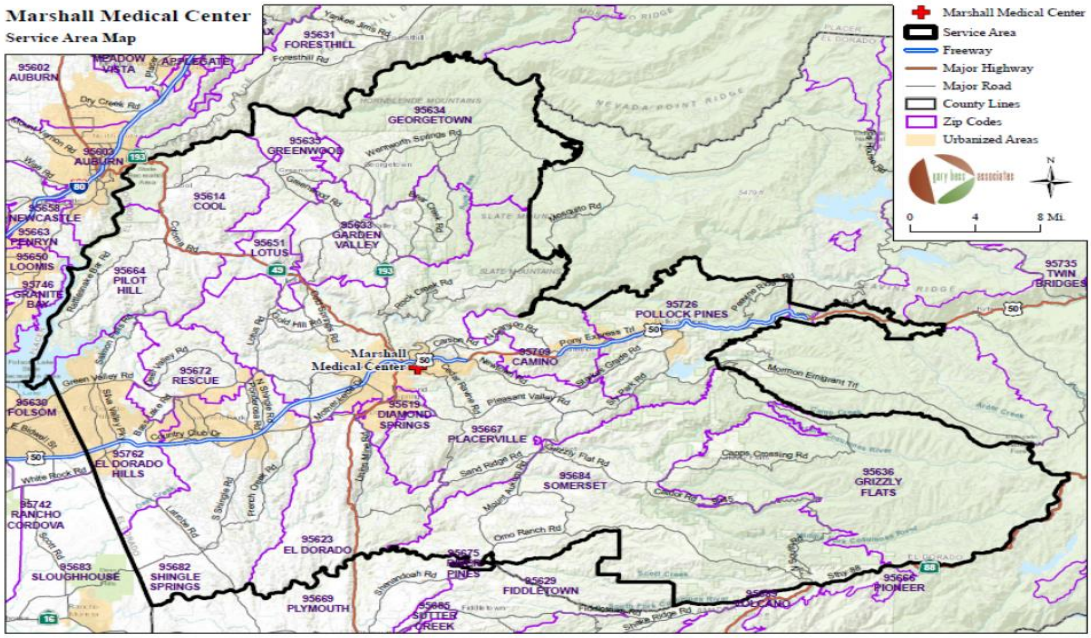
Definition of the Community Served

Marshall 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 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 Service Area

Geographic Area	ZIP Code
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

Marshall Service Area Map



Community Assessment

The 2025 CHNA process included collection and analysis of data sources for the hospital service area. Secondary data were collected from local, county, and state sources to present community demographics, social determinants of health, access to health care, birth characteristics, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and preventive practices. Where available, these data are presented in the context of El Dorado County and California, framing the scope of an issue as it relates to the broader community. Secondary data for the service area were collected and documented in data tables with narrative explanation. In addition, Marshall conducted interviews with 18 key community stakeholders to obtain input on health needs, barriers to care, and resources available to address the identified health needs. The collected data were used to identify significant community needs.

Significant Community Health Needs

The significant health needs identified in the 2025 CHNA are listed below in priority order. These identified significant health needs were analyzed by the hospital and then prioritized with community input through interviews with representatives from community-based organizations and surveys with community residents.

Significant Health Needs Listed in Priority Order

- Mental health
- Housing and homelessness
- Access to health care
- Substance use
- Food insecurity
- Chronic disease
- Overweight and obesity
- Preventive practices
- Unintentional injuries
- Climate hazards

Prioritized Health Needs the Hospital Will Address

Once the CHNA was completed, an internal group of hospital leaders met to discuss the significant health needs. The following criteria were used to determine the significant health needs the hospital will address in the Implementation Strategy:

Existing Infrastructure: There are programs, systems, staff, and support resources in place to address the issue.
Established Relationships: There are established relationships with community partners to address the issue.
Ongoing Investment: Existing resources are committed to the issue. Staff time and financial resources for this issue are counted as part of our community benefit effort.
Focus Area: The hospital has acknowledged competencies and expertise to address the issue and the issue fits with the organizational mission.

The CHNA served as the resource document for the review of significant health needs as it provided data on the scope and severity of issues and included community input on the health needs. The community prioritization of significant health needs was also taken into consideration. As a result of the review of needs and application of the above criteria, Marshall will address the following priority health needs:

Health Need: Access to Care

- Includes primary care services, specialty services, preventive care services, support services, and transitions of care

Health Need: Behavioral Health

- Includes mental health and substance use

Health Need: Coordination of Care for Chronic Conditions

- Includes prevention, management, and education related to chronic conditions and improving health outcomes in vulnerable populations, including housing and homelessness

Health Need: Improving Health Outcomes in Vulnerable Populations

- Includes Housing and Homelessness

Strategies to Address Prioritized Health Needs

For each priority health need the hospital plans to address, the Implementation Strategy describes the actions the hospital intends to take, including programs, tactics and resources it plans to commit, anticipated impacts of these actions, and planned collaboration between the hospital and other organizations. Community stakeholders were actively engaged in the development of this plan through participation in two workshops held on 12/15/25 and 1/26/26. The list of community participants can be found in Appendix 1.

Health Need: Access to Care Includes Primary Care Services, Specialty Services, Preventive Care Services, Support Services, and Transitions of Care	
Objectives	• Increase access to services and resources to improve the health and welfare of community residents and meeting people where they are, reflecting the diverse needs of people across the community. • Facilitate access to, and education on services for those challenged by location, social needs, age and/or vulnerability.
Anticipated Impact	• Increase access to health care and supportive services and reduce barriers to care. • Increase the availability of support services in community settings through collaboration with community partners.
Goal	• Achieve measurable and sustained improvements in access to primary care, pediatrics and behavioral health. o Achieve 10% improvement year over year for third next available appointment[1] for primary care, pediatrics and behavioral health, either in person or through telehealth.
Strategy or Program	**Summary Description**
Coordination of Services	Advance coordination of services with other agencies and providers to improve access to services and care.
Expand Outreach Capabilities	Maximize opportunities to leverage systems, processes, and partnerships to achieve improved access to care. Include provision of mobile health care to residents with limited transportation, those who are elderly, rural or are experiencing homelessness to support wound care, mental health and addiction, diabetes management, heart disease, medication adherence, substance use care, and family planning.
Shared Exchange of Health Information	Improve the ability to share health information across providers and organizations within the community. Enhance interagency collaboration and create a system to search for and target services to those with needs. In

[1] Third next available appointment is a standard metric to represent accessibility of care. It reduces representation of or reliance on “one-off” available appointments and measures the date differential between the third next available appointment and the current date.

Health Need: Access to Care Includes Primary Care Services, Specialty Services, Preventive Care Services, Support Services, and Transitions of Care	
	addition, assist in closing the loop on referrals for services and follow-up to care.[2]
Tactics	**Activities Through Which the Strategies Can Be Achieved**
Chronic Disease Performance Metrics	Implement guidelines to ensure use of common metrics to measure performance with chronic disease prevention and management.
Community Support	Provide donations and in-kind support to nonprofit community organizations dedicated to addressing access to health care and providing support services.
EMS Capabilities	Enhance EMS capabilities to trigger referrals to community entities and coordination with mobile crisis services.
Mobile and Tele-Health	Expand mobile and tele-health care to residents with limited transportation, those who are elderly, rural or are experiencing homelessness to support wound care, mental health and addiction, diabetes management, heart disease, medication adherence, substance use care, and family planning.
Pharmacy Access	Directly address barriers to pharmacy access, including transportation to pharmacies and home delivery services.
Planned Partnerships and Collaborators	Community health centers and community clinics Community-based organizations El Dorado County Continuum of Care El Dorado County Health and Human Services Agency El Dorado County Libraries El Dorado County Sheriff's Department El Dorado Transit Emergency Medical Services Homeless service agencies Partner mobile health service events (Crisis, Behavioral Health, Dental, Sheriff's HOT) Placerville Police Department Senior Nutrition Program Senior service organizations Snowline Upper Room

[2] Health Information Exchange and Closed Loop Referral definitions – while each have a formal definition, particularly for use by the California Department of Health Care Services (DHCS), the terms are used more generally in this document. Please see the links below for the DHCS-related information.

- Link: Closed-Loop-Referral-FAQs
- Link: Home - California Data Exchange Framework

Health Need: Behavioral Health Includes Mental Health and Substance Use	
Objectives	• Increase access to and coordination of mental health and substance use services in the community, with a particular focus on reducing stigma and coordinated navigation. • Improve screening and identification of mental health and substance use needs and reduce stigma to diagnosis and management.
Anticipated Impact	• Improve screening, prevention, and treatment of mental health conditions and substance use disorders.
Goal	• Achieve measurable and sustained improvements in access to and the coordination of behavioral health and substance use disorder services in the Community. o Improve the rate of successful enrollment in programs for the management of SUD and behavioral health services by 10% year over year.
Strategy or Program	**Summary Description**
Behavioral Health and Substance Use Program Coordination and Integration	Further develop the Bridge Program to support the transition of people presenting to the Emergency Department, those being released from incarceration or under supervision by probation to ongoing care in the community. Improve the coordination of substance use and behavioral health services for individuals in these programs.
Crisis Management	Increase access to services and the coordination of care for those experiencing behavioral health crises, including services that support people in the community and assist in avoidable use of emergency and hospital services.
Medication Assisted Treatment (MAT) Coordination	Provide access to and coordination of Medication Assisted Treatment (MAT) for opioid addiction. Offer participation in MAT programs, whether CARES or external programs, for people who seek care in Marshall's Emergency Department. MAT includes buprenorphine to alleviate withdrawal symptoms. Coordinate ongoing care with service providers within the community as well as the communities in which people may live.
Tactics	**Activities Through Which the Strategies Can Be Achieved**
Advancing Marshall CARES (Clinically Assisted Recovery & Education Services) & Medication Assisted Treatment (MAT) Coordination	Focus on access to and coordination of support treatment for persons with 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.
Care Coordination	Strengthen partnerships between organizations and agencies to improve care coordination and positively impact crisis outcomes.
Community Support	Provide donations and in-kind support to nonprofit community organizations that address behavioral health and substance use services.

Health Need: Behavioral Health Includes Mental Health and Substance Use	
Consistency of Approach	Build trust and rapport. Deliver the same message consistently over time with assessment of needs and the provision of services.
Health Education and Outreach	Provide substance use and misuse education to increase community knowledge of substance use issues, to increase awareness of prevention and treatment services available in the community and reduce stigma to diagnosis and management.
Removal of Barriers	Break down silos that exist between programs and support warm handoffs between providers.
Planned Partnerships and Collaborators	Asociacion Guadalupana California Healthcare Foundation Center for Violence Free Relationships Community-based organizations El Dorado Community Health Center (EDCHC) El Dorado County ACCEL El Dorado County CAO Office El Dorado County Continuum of Care El Dorado County Department of Education El Dorado County Health and Human Services Agency El Dorado County Opioid Coalition El Dorado County Probation and Parole El Dorado County Public Guardian El Dorado County Substance Use Disorder Services Faith-based organizations Fire and EMS Law enforcement agencies NAMI El Dorado County Clubhouse El Dorado Progress House Schools and school districts Senior service agencies Shingle Springs Tribal Health and Wellness Sierra Harm Reduction Coalition Youth organizations (sports clubs, Boy Scouts, Girl Scouts, New Morning)

Health Need: Coordination of Care for Chronic Conditions Includes Prevention, Management, and Education Related to Chronic Conditions	
Objectives	• Support everyone in the community to reach their highest desired state of health and wellbeing through the improved coordination of services. • Improve the availability of and access to services and resources to reduce the impact of chronic conditions on health. • Increase the focus on chronic disease prevention and treatment.
Anticipated Impact	• Improve wellness and screening, prevention, and treatment of chronic diseases. • Increase compliance with chronic disease management recommendations. • Increase healthy eating and active living.
Goal	• Demonstrate active support for individuals with chronic conditions to improve adherence to plans of care. o Improve enrollment in programs providing active management for chronic conditions by 10% year over year.
Strategy or Program	**Summary Description**
Chronic Disease Treatment.	Support people to manage chronic conditions through the coordination of care across the community and leveraging programs of support, including Marshall's Congestive Heart Active Telephone Treatment (CHATT) and Diabetes and Nutrition Education (DNE) programs, along with other similar programs supported by partner organizations.
Population Health	Coordinate community care services to remove gaps and overlaps, with the objective of strengthening the continuum of care provided to patients and the community. Marshall will focus on expanding and maximizing opportunities for screenings for breast cancer, colon cancer, and diabetes.
Tactics	**Activities Through Which the Strategies Can Be Achieved**
Cancer Resource Center	Provide classes, support groups, and services to include nutrition consultations, navigation, transportation, lodging assistance, case management, no-cost mammograms, and colorectal screening kits.
Collaboration	Actively collaborate to create partnerships and processes to prevent and respond to issues that cross boundaries of responsibility. Work to remove legal, technical, and operational barriers to improve sharing of information. Establish shared metrics to assist in performance measurement across the community.
Community Care Network (CCN)	Improve the effectiveness and quality of care for high-risk patients. Assist chronically ill patients with health care coordination and management, in-home care, medical supplies, and volunteer health coaches. Reduce readmissions and preventable emergency room visits. Work with people to address their needs, meet them where they are at, navigate their paths to improved health and wellbeing, and overcome barriers to care.
Community Support	Provide donations and in-kind support to nonprofit community organizations dedicated to addressing chronic diseases and healthy living strategies.

Health Need: Coordination of Care for Chronic Conditions Includes Prevention, Management, and Education Related to Chronic Conditions	
Coordination of Services	Improve coordination of patient focused services across agencies in the county, including a focus on specialty care. Concentrate on logistical needs: the delivery of care to the right people, through the right process, at the right place, and at the right time.
Health Education and Outreach	Provide community health sessions focused on chronic disease prevention, management, and treatment, weight loss, smoking cessation, and end-of-life planning.
Healthy Living and Chronic Disease Prevention	Foster a community environment that supports chronic disease prevention and treatment, including encouraging people to take ownership for their own health, and improving local access to healthy foods, opportunities for exercise, and support for wellbeing.
Planned Partnerships and Collaborators	American Heart and Lung Associations Blue Zone Initiatives Community health centers and community clinics Community-based organizations El Dorado County Health and Human Services Agency El Dorado County Office of Education Faith-based organizations Images of Hope Kiwanis Parks and Recreation Department Red Cross Rotary Schools and school districts Senior service agencies Senior/Retirement Communities (Ponte Palmero, Four Seasons, Lakeside) Veterans' organizations Youth organizations (sports clubs, Boy Scouts, Girl Scouts, New Morning)

Health Need: Improving Health Outcomes in Vulnerable Populations[3] Includes Housing and Homelessness	
Objective	• Increase access to services and resources to improve the health and welfare of vulnerable populations within the community, including those challenged by geographic location, social needs, age, and/or involvement in the justice system.
Anticipated Impact	• Increase access to supportive services and reduce barriers to care for vulnerable populations. • Facilitate the availability of support services in community settings through collaboration with community partners.
Goal	• Achieve measurable and sustained improvements in the health status of at least one vulnerable population. o Establish a Patient Centered Medical Home[4] and target the enrollment of at least one vulnerable population.
Strategy or Program	**Summary Description**
Care Coordination for Vulnerable Populations (CCVP)	Provide trauma-informed care to vulnerable populations, recognizing the importance of cultural humility. Ensure availability of care at locations throughout El Dorado County with services and closed loop referrals that include medical coordination, mental health, housing navigation, benefits assistance, transportation support[5].
Financial Assistance for the Uninsured or Underinsured and Insurance Enrollment Support	Provide financial assistance using available programs for low-income patients for health care services, consistent with the hospital's financial assistance policy. Address opportunities for HICAP support for seniors.
Health Equity Program Development, Reduce Barriers to Care	Build improved systems to identify populations with high health-related social needs and disparate outcomes in quality of care or chronic condition management to better understand community needs, strengthen community partnerships and develop thoughtful interventions. Ensure Health Equity action planning is completed at least annually to meaningfully intervene in disparate health outcomes.
Tactics	**Activities Through Which the Strategies Can Be Achieved**
Health Insurance Enrollment	Assist people who are uninsured or underinsured to enroll in publicly available health insurance programs.

[3] Definition of Vulnerable Populations per HCAI linked below. Marshall explicitly includes incarcerated individuals and those involved in the Justice system.
- Link: Hospital Community Benefits Plans Program - Vulnerable Populations Fact Sheet - March 2022 Final
- Link: DHCS Justice-Involved Initiative Home

[4] A Patient-Centered Medical Home (PCMH) is a care delivery model designed to improve patient outcomes through coordinated, team-based primary care. In a PCMH, providers take a holistic approach to health management — emphasizing long-term patient relationships, accessibility, and proactive care planning rather than episodic treatment.

[5] This program assists those with the highest risk for health complications, unmanaged chronic conditions, and other social complexities. Vulnerable populations served by the program include persons who are unsheltered/homeless, the elderly, women, Latino communities, those released from incarceration or under probation. Programs include a navigation program centered around life skills to decrease avoidable ED visits, decreasing missed medical appointments, as well as enrolling in health insurance and free medication programs.

Health Need: Improving Health Outcomes in Vulnerable Populations[3] Includes Housing and Homelessness	
Multi-Agency Partnerships	Partner with community-based resources to expand reach and impact, particularly Mobile Medical Unit services provided through El Dorado Community Health Center and various Public Health related programs.
Patient Centered Medical Home (PCMH)	Develop the PCHM model to provide and maintain a trusted, safe, easily accessible health hub for vulnerable populations. Apply this model to hard-to-reach populations with multiple challenges (age, homelessness, behavioral health issues) to demonstrate effectiveness in breaking down silos to care. Use a common PCMH accreditation body across the County (NCQA).
Transportation Services	Support meeting transportation needs for people who can't afford transportation to or from medical services and appointments. Improve access to transportation resources, addressing the challenges of inconsistent transportation access provided by different health plans.
Planned Partnerships and Collaborators	American Red Cross Community Action Council Community health centers and community clinics Community-based organizations EDCOE El Dorado County Continuum of Care El Dorado County Health and Human Services Agency El Dorado County Libraries El Dorado County Probation El Dorado County Sheriff's Department El Dorado Transit Emergency Medical Services Faith-based organizations Food banks Homeless service agencies Libraries Placerville Police Department Senior service organizations TANF Tribal Health Upper Room Veterans' Services Volunteers of America

Evaluation of Impact

Marshall is committed to monitoring and evaluating key initiatives to assess the programs and activities outlined in this Implementation Strategy. 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 the hospital's actions to address these significant health needs will be reported in the next scheduled CHNA.

Health 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 we can most effectively address given our areas of focus and expertise. Taking existing hospital and community resources into consideration, Marshall will not directly address the remaining health needs identified in the CHNA, including climate hazards, food insecurity, and unintentional injuries.

Appendix 1. Community Stakeholder Workshop Participation

Name	Affiliation
Anderson, Ben	El Dorado County Fire Deputy Chief
Camisa MD, Leanne	Marshall Chief of Staff and Wellness Officer
Ceridon MD, Sam	Marshall Family Medicine Provider
Chaabo MD, Hani	El Dorado County Health Center Chief Clinical and Wellness Officer
Collinsworth, Justine	El Dorado County Health and Human Services Behavioral Health Director
Cordero, Tim	El Dorado County Fire Chief
Entwistle MD, Martin	Marshall Chief of Medical Affairs
Fliflet, Kyle	El Dorado County Health and Human Services Public Health Director
Green, Jenna	El Dorado County Health Center Chief Operations Officer
Knight, John	Marshall Board of Directors Member
Lemos, Andrew	El Dorado County Fire Deputy Chief
Manansala, Ed	El Dorado County Office of Education Superintendent of Schools
Nelson, Kyle	Shingle Springs Tribal Health and Wellness Center Executive Director
Neufeld NP, Lacey	Marshall Family Nurse Practitioner
Palmberg, Eric	El Dorado Sheriff Office Undersheriff
Payne, Nichole	Housing El Dorado Executive Director
Peigh, Rachel	Marshall VP Operations
Pooley, Amy	El Dorado Community Foundation Executive Director
Powell, Lisbeth	El Dorado County Commission on Aging
Rabinowitz, Diane	NAMI El Dorado County President
Santana, Deanna	El Dorado County Office of Education Director of Child, Family, Community Services
Shanks, Chelsey	Marshall Director Emergency Department and Respiratory Therapy
Smart, Penny	Marshall Health Equity Program Manager
Sornborger, Kristin	Marshall Occupational Health Nurse Practitioner
Vasconcellos MD, Scott	Marshall Cardiologist
Veerkamp, Brian	Marshall Board of Directors Member
Weston, Chris	Access El Dorado (ACCEL) and Coalition for Overdose Prevention and Education (COPE) Project Director
Wise, Seth	El Dorado Youth Action Council and COPE Member