Marshall

HCAI Hospital ID: 106090933

Annual Report and Plan for Community Benefit

November 1, 2024 – October 31, 2025

Submitted to:

Department of Health Care Assessment and Information (HCAI)

Accounting and Reporting Systems Section

Sacramento, California

Contents

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 103 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.

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 has opened. 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.

Marshall's Emergency Department is a verified Level III Trauma Center, and the Stroke Program is recognized as a Primary Stroke Center by the Joint Commission. Marshall's Birth Center is designated by the World Health Organization and UNICEF as a Baby Friendly® certified facility for breastfeeding advocacy.

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 2025.

Vision, Mission, and Strategic Plan

Vision

Marshall's vision, which has been adopted by the Marshall Board to reflect the Organization's core purpose and communicated widely to providers, staff and the community:

> "A world where everyone can achieve 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.

Values and Principles

Marshall has continuously adjusted the language utilized to communicate our priorities while remaining steadfast in our foundational commitment to serving our community's needs for the long-term future. In the latest iteration, we have further simplified our focused "anchors" to create clarity and alignment. The Marshall community -- employees, medical staff, volunteers, and leadership -- embrace the following values and principles:

- **People First.** Lead with our hearts, fostering an environment where everyone feels seen, heard, and cared about.
- **Excellence.** Relentless pursuit of perfection driven by a commitment to quality, integrity, and continuous improvement.
- **Purposeful Evolution.** Embracing intentional change and driving innovation.

Strategic Goals

Following our refreshed, simplified pillars or fundamentals of success, Marshall has updated our strategic goals to support meeting our community's health needs.

1. Advance our Ecosystem to attract and retain top talent.
2. Foster strategic growth and ensure long-term sustainability.
3. Achieve and maintain the highest standards of clinical and operational excellence.

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 health care 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. To expand the Board's community impact and organizational governance, a Community Engagement Committee (CEC) has been formed. The CEC ensures Marshall follows through in purposefully evolving to proactively meet Community Health Needs. The CEC was consulted on the development of the community benefit plan.

Board of Directors

Tom Cumpston, Chair
John R. Knight, Vice Chair
Sylvia Stephenson, Secretary
Anna Blair, RN, Treasurer
Leanne Camisa, MD, Chief of Staff
Siri Nelson, President and CEO
Jon Haugaard, Immediate Past Chair
Gerardo Galang, MD,
Alexis Long, MD
Mike Pervis
Kim Stoll
Brian Veerkamp

Community Engagement Committee

Martin Entwistle, MB, ChB, FRCSEd, Marshall
Maia Schneider, Marshall
Alexis Long, MD, Marshall Emergency Department and the Wound Care Center
John Knight, Los Rios Board Trustee
Brian Veerkamp, District III Supervisor of El Dorado County
Doug Hawkins, RN, Gold Country Health Center
Michael Saunders, MD, Georgetown Divide Public Utility District

Caring for our Community

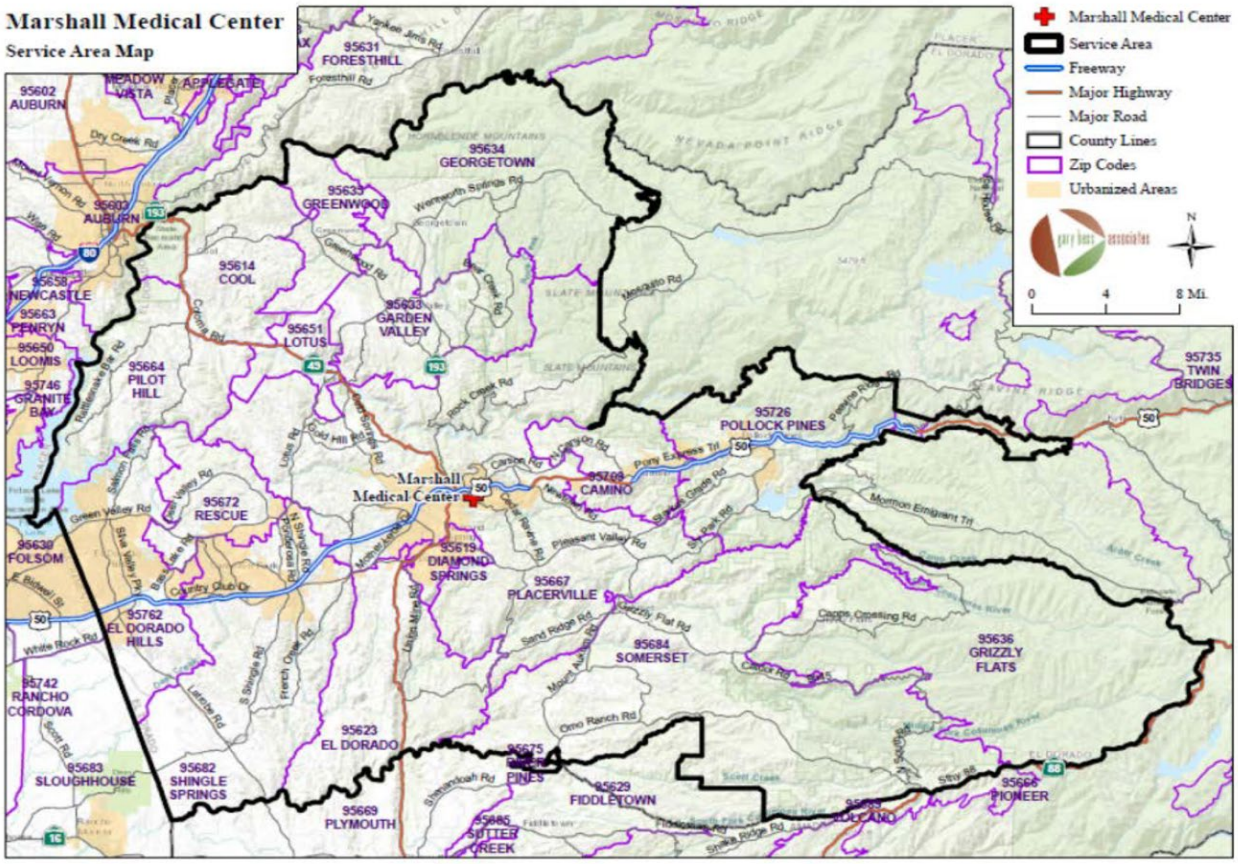
This report demonstrates tangible ways in which Marshall is fulfilling its mission to promote health improvement and provide health services to our community. In accordance with its Financial Assistance policy, Marshall supports those in the community who cannot afford services, or whose health insurance 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 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 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

Community Indicators	Service Area
Population	162,213
Population Growth (2018-2023)	3.3%
Children and Teens, Ages 0-17	20.3%
Adults, Ages 18-64	56.1%
Seniors, Ages 65 and Older	23.6%
White Residents	75.9%
Hispanic or Latino Residents	12.5%
Asian Residents	4.9%
Black or African American Residents	0.9%
Spanish Spoken in Home, Ages 5 and Older	4.4%
Asian or Pacific Islander Language Spoken in Home, Ages 5 and Older	2.9%
Does Not Have a High School Diploma (25 Years and Older)	4.5%

Vulnerable Populations

Community Indicators	Service Area
Poverty Level	7.9%
Low-Income (<200%FPL)	17.3%
Has Health Insurance, Total Population	97.0%
Has Health Insurance, Ages 0-18	98.0%
Medi-Cal Coverage, El Dorado County	8.2%
English Learners, El Dorado County School District Students	5.8%
Total Homeless Population, El Dorado County	284
Unsheltered Homeless Population, El Dorado County	47.5%
California Healthy Places Index, Inadequate Access to Clean Air and Safe Drinking Water	67.8%

Community Health Needs Assessment

Marshall completed a Community Health Needs Assessment (CHNA) in FY25 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, access to health care, birth characteristics, leading causes of death, 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 Marshall. Eighteen (18) interviews were conducted by phone during May and June 2025. 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. Stakeholder interviews 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 health needs included (in alphabetical order):

- Access to care
- Chronic diseases
- Climate hazards
- Food insecurity
- Housing and homelessness
- Mental health
- Overweight and obesity, healthy eating and physical activity
- Preventive care
- Substance use
- Unintentional injuries

These significant health needs were then prioritized with input from the community. The community stakeholders were asked to rank order the significant health needs according to highest level of importance in the community. Mental health, housing and homelessness, access to health care, and substance use were ranked as the top four priority needs in the service area.

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 FY25, 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 (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 treats opiate use disorder and has grown into a clinic focused on supportive treatment for people with any substance dependency, including alcohol, tobacco, stimulants, opioids, benzodiazepines, and other sedative hypnotics. Clinic services served 833 people and included 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 come to Marshall's Emergency Department in withdrawal, they work with a Substance Use Navigator (SUN) and 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. In FY25, the SUN consulted with 833 people. Beyond opioid use disorder treatment, Marshall has also engaged to support treating alcohol use disorder, nicotine use disorder, as well as methamphetamine use. Fentanyl-specific use and overdose continues to rise as significant public health impact due to its highly concentrated and often polluted nature, particularly in semi-rural western El Dorado County.

Overdose Recognition and Prevention

Outreach to the community for education on substance use treatment, overdose prevention and stigma reduction. Marshall reached 230 people at a Fentanyl and Overdose Awareness Day. Overdose education and prevention reached 130 high school students. Opioid prevention community education reached 90 people. Over 700 people were provided with Narcan for use in the community.

Staff at Marshall led the Substance Use Disorder Board for interdisciplinary review and education regarding care for current and emerging substance use disorders and participated in the El Dorado

County Perinatal SUD Treatment Collaborative. And outreach and resource navigation were provided for individuals and their families experiencing substance use disorders.

Marshall provided collaborative community support with St. Patrick's Church. This collaboration supported underserved populations and provided assistance with community resource navigation, including substance use disorder (SUD)–related support and referrals for residents at Mother Teresa Maternity Home residential program for pregnant mothers.

Outreach and community intervention activities connected 545 community members to health, behavioral health, and substance use disorder–related education and resources. Outreach and engagement occurred at Woodridge Apartments, Cedar Grove Mobile Home Park, Cottonwood Apartments, Santa Maria Taqueria, La Promesa, and Exhilaration Station. These activities supported access to culturally responsive outreach, resource navigation, and community-based interventions aimed at improving connection to care and support services for underserved populations.

Chronic Disease Prevention, Management and Treatment
Response to Need

Population Health

The Marshall Population Health team coordinated the community services that Marshall provided, 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 a particular focus on screenings for breast cancer, colon cancer and diabetes and met or exceeded its performance targets in all three areas. Population Health, in addition to coordinating health promotion activities for existing patients, completed outreach events reaching over 200 people to educate the community regarding cancer screenings and health promotion activities.

Flu Vaccines

Within the Vulnerable Populations Street Nursing program, Marshall provided 15 people with flu vaccine clinics in the community in FY25 while many more vaccines were provided through normal course of patient care.

Community Care Network (CCN)

CCN focuses on improving the effectiveness and quality of care for high-risk patients. Through the Community Care Network (CCN) high risk patient case management, Transitional Case Management (TCM) and Enhanced Care Management (ECM) Programs, Marshall 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. These programs reduce readmissions and unnecessary emergency room visits. For people 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 navigate their paths to improved health and overcome community barriers. In FY25, 7,484 encounters were provided to people through these CCN programs.

Congestive Heart Active Telephone Treatment (CHATT)

The CHATT program helped people manage congestive heart failure (CHF). 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 FY25, CHATT provided 7,346 encounters for care.

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 accessing health care, especially in rural areas. The Cancer Resource Center provided 132 one-way rides as well as provided 470 gas cards.
- The Wig Bank served 24 people.
- Provided 49 no-cost mammograms.
- Provided lodging assistance for two people who could not afford the cost of a hotel room while obtaining cancer treatment.
- Participated in a community wide Making Strides Against Breast Cancer Prevention Event.
- Nutrition consultations and services reached 229 people.
- 386 people with cancer were provided with case management navigation services.
- 260 people received psychosocial distress screening
- Social work consultations and services assisted 366 people.

Health Education and Outreach

In FY25, Marshall reached 655 community members with the following community health education sessions:

- Cancer exercise
- Fall prevention
- Joint care
- Stroke education and support group
- Weight loss management

Marshall participated in and/or sponsored community events to raise awareness about chronic disease and to provide outreach and education including: the American Heart Association Heart Walk, Marshall Gold Country 5K, Cancer Association Survivors 5K, and the Georgetown Health Fair,

NIH STRIVE Study for Cardiac Rehabilitation

Marshall Cardiac Rehab has partnered with UC Davis and UCSF to provide virtual health coaching and psychosocial support to help maintain physical activity after a cardiac event. Clients perform baseline exercise testing measurements and review habits. Clients are given a Fit Bit for exercise tracking purposes as well as virtual access to health coaching. In 2025, five people participated in the program.

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's financial assistance policy. Offered assistance to enroll in public health insurance programs.

Transportation

Provided transportation to 52 people who could not afford transportation to or from medical services and appointments.

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 FY25, 940 community members accessed these services.

Street Nursing and Outreach Program

The Street Nursing and Outreach program provided trauma-informed care directly to unhoused and unstably housed community members. The team provided direct medical care, addressing chronic diseases, acute illness, wound care, medication access, and health education. Mobile care was delivered at encampments, shelters, and transitional housing sites, helping patients manage health conditions outside of traditional care systems. The programs provided care at locations throughout El Dorado County, including the Placerville and Georgetown Libraries, Upper Room Dining Hall, Green Valley Church Shower Program, and the Navigation Center operated by Volunteers of America.

Services included medical coordination, mental health referrals, housing navigation, benefits assistance, transportation support, and resource distribution (e.g., hygiene kits, food, clothing, tents, and medical supplies). The Street Outreach team served 627 people in FY25. They provided 1,554 phone contacts and referrals for 178 people. They hosted outreach events, trainings, and flu clinics.

Emergency Evacuation Shelter Clinic Planning

In addition to the services provided above, the Street Nursing and Outreach program has undertaken emergency preparedness planning to build the infrastructure necessary to deploy an emergency evacuation shelter medical/nursing clinic. Marshall has provided these services in the past and have analyzed the components necessary to deploy rapidly and provide sufficient care in the community. The program now has a trailer prepared with urgent care supplies, electronic equipment for registration and documentation, vital sign equipment, and first aid/minor wound care supplies. This ensures that our vulnerable populations are able to rapidly and proactively receive care while displaced and that Marshall is prepared to respond with urgency.

Trauma Services

Marshall provided community education, outreach and resources to reduce injuries and accidents. They reached over 1,000 people at these events:

- Divide Wellness Fair
- Every 15 Minutes
- Folsom Family Expo
- Wild Fire Safety Day

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 FY25, Marshall staff instructors trained 150 El Dorado County residents, which included online courses and in-person training.

Food Distribution

Food was distributed to 44 families experiencing food insecurity.

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 FY25 included Alzheimer's disease, injury prevention, cancer treatment, heart disease and diabetes.

Other Community Benefit Services

Marshall 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.

Medical Assistant School

In partnership with El Dorado County Office of Education, Marshall uplifted a Medical Assistant school program. Marshall provided the physical school site, many physical resources and training materials, as well as the clinical site for rotations.

Nursing

A total of 41 Registered Nurse students, and 16 Nurse Practitioners received precepted training. The MSN Quality Project provided mentorship for one masters level nursing student.

Other Health Professions

Marshall served as a health education training site for:

- 1 Clinical Lab Scientist
- 8 Diagnostic Imaging students (Ultrasound, Radiology Technician, Mammography Technician)
- 26 Medical Assistants
- 1 Occupational Therapist
- 20 Paramedic students/Emergency Medical Technicians
- 5 Pharmacy students
- 1 Phlebotomist
- 2 Physical Therapists
- 5 Respiratory Therapists
- 1 Social Work Student
- 2 Speech Language Pathologists
- 2 Surgical Technicians

Marshall is a clinical rotation site for physician assistants from Stockton's University of the Pacific. In 2025, 17 physician assistants received clinical precepting.

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 social determinants of health.

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

Through the High School ROP/Medical Arts program, 36 students participated in Health Career Shadowing and 33 students participated in a health career day.

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 financial summary of community benefit for FY25 (November 1, 2024 to October 31, 2025) appears in the table below. The Hospital's community benefit costs comply with Internal Revenue Service instructions for Form 990 Schedule H. Costs are estimated using the hospital's cost accounting system. Appendix 1 lists the community benefit programs by category.

Financial Assistance and Means-Tested Government Programs	Vulnerable Populations	Broader Community	*Total*
Traditional Charity Care	$4,441,521	$0	$4,441,521
Medi-Cal Shortfall	$1,047,640	$0	$1,047,640
Other Means-Tested Government Programs (Indigent Care)	$0	$0	$0
Sum Financial Assistance and Means-Tested Government Programs	$5,489,161	$0	$5,489,161
Other Benefits			
Community Health Improvement Services	$436,404	$3,171,856	$3,608,260
Community Benefit Operations	$0	$87,278	$87,278
Health Professions Education	$0	$3,991,875	$3,991,875
Subsidized Health Services	$0	$0	$0
Research	$0	$0	$0
Cash and In-Kind Contributions	$14,782	$161,916	$176,698
Other Community Benefit	$0	$269,817	$269,817
Total Other Benefits	$451,186	$7,682,742	$8,133,928
Community Benefit Spending			
Total Community Benefit*	$5,940,347	$7,682,742	$13,623,089
Medicare (non-IRS)	$61,950,764		$61,950,764
Total Community Benefit with Medicare	$67,891,111	$7,682,742	$75,573,853

*Sum of Financial Assistance, Means-Tested Government Programs and Other Benefits

Community Benefit Plan FY26

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 address the following health needs that were identified in the FY25 CHNA and detailed in the FY26-FY28 Implementation Strategy:

- Access to Care - Includes primary care services, specialty services, preventive care services, support services, and transitions of care.
- Behavioral Health - Includes mental health and substance use.
- 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.

Access to 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.

Strategies

1. Advance coordination of services with other agencies and providers to improve access to services and care.
2. 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.
3. 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 addition, assist in closing the loop on referrals for services and follow-up to care.

Behavioral Health (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.

Strategies

1. 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.
2. 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.
3. 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.

Coordination of Care for 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.

Strategies

1. 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.
2. 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.

Improving Health Outcomes in Vulnerable Populations

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.

Strategies

1. 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.
2. 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.
3. 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

Evaluation of Impact

Through the CHNA process, community stakeholders provided input on the community health needs impacting the community, prioritization of the needs, and resources to address the needs. Appendix 2 identifies the community groups and local officials that were consulted.

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

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. Taking existing medical center and community resources into consideration, Marshall will not directly address the remaining health needs identified in the FY25 CHNA, including climate hazards, food insecurity, 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

Marshall
1100 Marshall Way
Placerville, CA 95667
https://www.marshallmedical.org/

Community Benefit Contact
Rachel Peigh, RN
Vice President of Operations (and Population Health)
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Dr. Martin Entwistle
Chief of Medical Affairs
mentwistle@marshallmedical.org

Appendix 1: Categorization of Community Benefit Programs

Medical Care Services
Charity care/financial assistance
Medi-Cal shortfall
Medicare shortfall (non-IRS)
Other Benefits for Vulnerable Populations
CARES Behavioral Health Clinic
Cash and -in-kind donations to support nonprofit organizations
Community food distribution
Enhanced Care Management
Financial assistance for the underinsured and uninsured
Homeless encampment collaboration
Preventive care clinics and screenings
Senior health fairs
Street nursing outreach
Transportation assistance
Other Benefits for the Broader Community
Cancer Resource Center
Cash and -in-kind donations to support nonprofit organizations
CHATT (Congestive Heart Failure Telephone Treatment)
Childbirth education
Community benefit operations
Community Care Network
Fall prevention
For Your Health magazine
Health fairs
Injury prevention and safety education
Stop the Bleed
Stroke education and support groups
Substance use prevention education and outreach
Weight loss classes
Health Research, Education and Training Programs
Continuing medical education
Nursing precepting
Other health professionals precepting
Nonquantifiable Benefits
Economic development
Leadership development
Workforce development

Appendix 2: Community Stakeholders

Name	Title	Organization
Olivia Byron-Cooper, MPH	Director of Health and Human Services	El Dorado County Community Services
Tim Cordero	Fire Chief	El Dorado County Fire District
Dan Diggins	Director of Community Care	Green Valley Church
Shannon Maguire Estrada, RN-BSN, PHN, CCM	Outreach Coordinator for Vulnerable Populations and Case Manager	Marshall
Kyle Fliflet, MIPH	Deputy Director	El Dorado County Public Health
Robert Kamrath	Community member	
Margaret Lewis	Student Support Services Coordinator	El Dorado County Office of Education
Ed Manansala, EdD	County Superintendent of Schools	El Dorado County Office of Education
Nichole Paine	Program Coordinator	Housing El Dorado
Amy Pooley	Executive Director	El Dorado Community Foundation
Chris Proctor, MPT, MBA, FACHE	Director of Community Benefit and Business Development	Barton Health
Andrea Quintana, PA-C	Associate Medical Director	El Dorado Community Health Centers
Kirsten Rogers	Project Manager	ACCEL (Access El Dorado)
Caleb Sandford	Chief Executive Officer	El Dorado Community Health Centers
Kristin Sornborger, RN, MSN, FNP-BC	Family Nurse Practitioner; Trustee	Marshall Cardiology; Marshall Foundation for Community Health
Brian Veerkamp	Director	District III Supervisor, El Dorado County
Chris Weston, MPH, LMFT	Project Director	ACCEL (Access El Dorado)
Ruth Zermeno	Bilingual Human Services Specialist	New Morning Youth and Family Services