



Annual Report and Plan for Community Benefit
Marshall Medical Center
Fiscal Year 2021 (November 1, 2020 - October 31, 2021)

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About Marshall Medical Center

In the late 1950s a group of local citizens saw a great need for improved health care services in El Dorado County. The citizens formed a committee to petition the state of California for a nonprofit charter under which a hospital could be built and operated. As a result, plans were drawn, funds solicited, Michigan California lumber company donated land for a hospital site, and Marshall Hospital opened its doors in 1959. A group of dedicated employees worked to make the original 49 bed hospital a success. Marshall Medical Center derives its name from the pioneer James Marshall, who discovered gold at Sutter's Mill a few miles north of Placerville.

Marshall Medical Center (Marshall) is an independent, nonprofit community health care provider located in the heart of the Sierra Foothills between Sacramento and South Lake Tahoe. Marshall Medical Center 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; a group of primary care physicians and specialists; and community health and education programs. Marshall has approximately 190 affiliated physicians and a team of more than 1,600 employees providing quality health care services to more than 175,000 residents of Western El Dorado County.

At the Marshall Hospital and other clinic campuses in Placerville, health services include:

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

Awards

Marshall Medical Center was the recipient of a number of awards and accolades in FY21:

- 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.
- 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.
- American Heart Association’s Stroke Gold Plus with Honor Roll Elite in 2021 and Target: Type 2 Diabetes Honor Roll 2021.
- Named by California Health and Human Services, along with Cal Hospital Compare, for excellence in Opioid Care, Maternity and Patient Safety.
- Leapfrog Top General Hospital and Hospital Safety Grade “A” for 2021.
- Accreditation by the Commission on Cancer (CoC), a quality initiative program of the American College of Surgeons (ACS), for comprehensive patient-centered cancer care.
- Marshall is a California ED Bridge Program health facility, funded through the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Baby-Friendly birth facility.

Vision, Mission, and Values



Vision

We are a cohesive health care team that partners in delivering exceptional quality, access and value in all we do.

Mission

Marshall Medical Center 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.

Values

We at Marshall have dedicated our lives to healing, the prevention of illness and the promotion of wellness, working with chronically ill patients to help them live optimally within the limits of their condition. The Marshall community – employees, medical staff, volunteers, and leadership – embrace the following values:

- Our patients come first
- We respect privacy and confidentiality
- We are committed to our colleagues
- We are willing to change
- We uphold a professional work ethic
- We value communication
- We ensure a safe and clean environment

Caring for Our Community

Marshall Medical Center recognizes its obligation to provide service above and beyond its role as a healing facility. For over sixty years, Marshall has worked to promote the community's health and wellbeing. This report demonstrates tangible ways in which Marshall is fulfilling its mission to promote health improvement and provide health services of extraordinary value and quality 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.

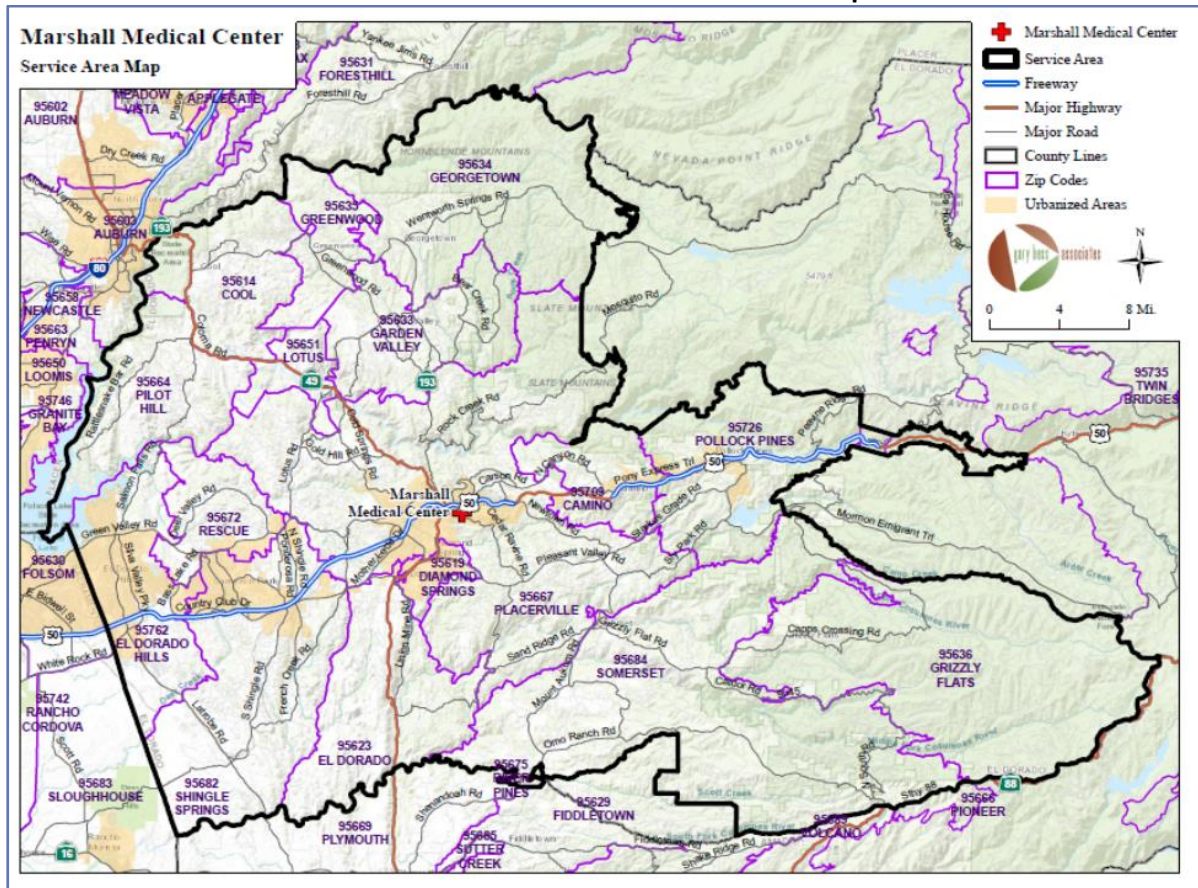
Service Area

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

Marshall Medical Center Service Area Map



Community Snapshot

The population of the Marshall Medical Center service area is 155,641. Children and youth, ages 0-17, make up 21.1% of the service area population, 59.3% are adults, ages 18-64, and 19.6% are seniors, ages 65 and older. The service area has a higher percentage of seniors than found in the county (18.9%) and the state (13.2%).

The majority of the population (80.0%) is White. At 10.7% of the population, Latinos or Hispanics are the second largest race/ethnic group in the service area. Asians make up 4.4% of the population in the service area. Black/African Americans are 0.8% of the population. The remaining races/ethnicities comprise 4.1% of the service area population.

Among area residents, 9.1% are living at or below 100% of the federal poverty level (FPL) and 21.1% are living at 200% of FPL or below (low-income). Almost half of area residents (48.8%) are high school graduates and 44.6% have a college degree.

Community Health Needs Assessment

Marshall Medical Center completed a Community Health Needs Assessment (CHNA) in 2019 as required by state and federal law. The CHNA is a primary tool used by the hospital to determine its community benefit plan, which outlines how it will give back to the community in the form of healthcare 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.

The CHNA examined up-to-date data sources for the service area to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, acute and chronic disease, health behaviors, mental health, substance use and misuse, and preventive practices. When applicable, these data sets were presented in the context of El Dorado County and California and compared to the Healthy People 2020 objectives.

Marshall conducted targeted interviews to gather information and opinions from persons who represent the broad interests of the community served by the hospital. Sixteen (16) interviews were completed from March to April 2019. 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 were represented in the sample. Input was obtained from El Dorado County Public Health staff.

Priority Health Needs

The list of significant health needs 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, discover gaps in resources and prioritize the significant health needs. The following criteria were used to prioritize the health needs:

- The perceived severity of a health issue or health factor/driver as it affects the health and lives of those in the community;
- The level of importance the hospital should place on addressing the issue.

Substance use and misuse, mental health and access to health care were ranked as the top three priority needs in the service area. The calculations of the community input resulted in the following priority ordering of the significant health needs:

1. Substance use and misuse

2. Mental health
3. Access to healthcare
4. Chronic diseases
5. Community safety
6. Overweight and obesity
7. Unintentional injuries
8. Environmental pollution
9. Preventive practices
10. Food insecurity

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. Please send your feedback to: mentwistle@marshallmedical.org.

Addressing Priority Health Needs

In FY21, Marshall engaged in activities and programs that addressed the priority health needs identified in the 2020 - 2022 Implementation Strategy. Marshall has committed to community benefit efforts that address: behavioral health (includes 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 Marshall commitment to community health are detailed below.

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

Positive mental health is associated with improved health outcomes. Indicators and contributors to poor mental health include poverty and low-levels of education.

Response to Need

Marshall CARES (Clinically Assisted Recovery & Education Services)

CARES was created to primarily 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. In FY21, the CARES team:

- Ensured the ED had an open door to treatment for substance use disorders. The department focused on treating opioid use disorder and providing life-saving treatment from drug withdrawal and post-overdose using buprenorphine.
- Participated in Opioid Coalition Meetings.
- Collaborated with a Behavioral Health Clinician at Shingle Springs Tribal Health and Wellness to discuss best practices.
- Strengthened community partnerships with El Dorado Community Health Center, El Dorado County Substance Use Disorder Services, Public Health Dept., El Dorado County Probation and Parole, and Progress House and worked to fill gaps and advance the care and treatment of people who use drugs in the community.
- Maintained an affiliation with El Dorado County Substance Use Disorder Services to help navigate patients into higher levels of care or connect them with additional resources.
- Supported positive relationships and coordinated care with multiple community partners in El Dorado County including: El Dorado Community Health Center, El Dorado County Substance Use Disorder Services, El Dorado County Probation and Parole, ACCEL, El Dorado Opioid Coalition, Sierra Harm Reduction Coalition and Progress House.
- Began contingency management services in FY21. Contingency Management is an evidence-based strategy specifically used to help people with stimulant use disorder.

- Utilized Substance Use Navigators, located in the hospital emergency department and Marshall’s Rural Health Center in Georgetown, to help patients who use drugs to navigate the continuum of care and connect to resources and higher levels of care.
- Participated in multiple community partnerships working to promote first person language, remove stigma, and promote access to care in rural areas of El Dorado County, including bringing MAT services to the Divide Wellness Center in the Georgetown area.

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. Because of its participation and success rate, Marshall was recognized as a star site in California and is used as a model for other hospitals to roll out a similar program.

- Marshall participated in the ACCEL Provider Capacity Workgroup Meetings, which included discussion of substance abuse/community and agency planning and collaboration and the El Dorado Community Health Center’s “C3 Clinic” (Complex Care Clinic for patients needing Medication Assisted Treatment of Substance Abuse Disorder).
- The Marshall Emergency Department Bridge program team has taken the lead on ensuring best practice protocols are in place for in-patient management of substance use disorder. This provided patient centered care and reduced the risk of post-admission overdose.
- Provided presentations and training on Medication Assisted Training and Harm Reduction.
- In FY21, Marshall Foundation for Community Health provided funding to agencies and organizations focused on addressing behavioral health.

Chronic Disease Prevention, Management and Treatment

Chronic diseases are long-term medical conditions that tend to progressively worsen. Chronic diseases, such as cancer, heart disease, and diabetes are major causes of disability and death. Chronic diseases are also the major causes of premature adult deaths.

Response to Need

Population Health

The Marshall Population Health team coordinated the community case services that Marshall delivered to remove gaps and overlaps, 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 to the patient. CCN removes obstacles that often prevent patients from receiving the routine and preventive care as well as 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. In FY21, 4,580 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 FY21, CHATT served 337 individual patients.

Cancer Resource Center

Marshall's Cancer Resource Center provides classes, support groups and services. Services are available to anyone impacted by cancer in El Dorado County, regardless of Marshall patient status. In FY21, the Cancer Resource Center provided:

- 175 nutrition consults/services and 122 psychosocial distress and nutrition screenings.
- 212 navigation consultations and 235 social work consultations.
- Transportation is a well-known barrier to health care, especially in rural areas. The Cancer Resource Center provided 84 persons with transportation services and 81 persons with gas cards.
- The Wig Bank served 23 persons.
- The Cancer Resource Center provided 40 no-cost mammograms.
- Marshall's *Quality Improvement Project: Colorectal Cancer Screening*, provided 600 FIT

kits to adults, between the ages of 50 and 64, who had no record of colorectal cancer screening.

- A cancer Survivorship Seminar series reached 13 people with three 1 ½ hour seminars.

Health Education

In FY21, Marshall provided the following community health education sessions:

- Joint replacement education
- Smoking cessation education
- Alzheimer's and Dementia education
- Bariatric surgery education
- Healthy Babies/lactation classes

Support for the Health and Welfare of the Community

Access to care is a key determinant of health that provides preventive measures and disease management, reducing the likelihood of hospitalizations and emergency room admissions.

Routine health care includes screenings, check-ups, and counseling to prevent illness, disease, or other health problems. Individuals, who receive services in a timely manner, have a greater opportunity to prevent or detect disease during earlier, treatable stages.

Response to Need

Care Coordination for Vulnerable Populations (CCVP)

CCVP is an interdisciplinary program that reaches the most vulnerable populations in El Dorado County. This navigation support program assists those who present the highest risk for health complications, unmanaged chronic conditions, and other social complexities. Vulnerable populations served by the program included: unsheltered/homeless, the elderly, women and Latino communities. Programs included a navigation program centered around life skills to decrease avoidable ED visits, decreasing missed medical appointments, and infection control.

Mobile Medicine/Rural Outreach Program

Provided in collaboration with El Dorado County Health and Human Services, the program provides mobile health care to residents with limited transportation, those who are elderly, rural or are homeless. Care addresses wound care, mental health and addiction, blood sugar and blood pressure management, as well as diabetes management, heart disease, medication adherence, substance use care, and family planning. However, over the past year, the need to provide COVID-19 vaccines has become a priority.

- Mobile services reached homeless camps, cabins in the woods and the elderly in their homes who were inhibited in accessing care by a lack of transportation or other barriers.

- Clinical services were provided at Library Hubs on library campuses throughout the county.
- In FY21, volunteers were trained in the navigation for vulnerable populations program.

Response to COVID-19

[Telehealth Services](#)

The hospital procured 70 iPads for physician use, making telehealth services possible. Virtual visits have been widely accepted and embraced by patients, especially those with chronic or acute issues. iPads were also used for ICU patients to communicate with their families, alleviating their anxiety and isolation.

[Drive Through COVID-19 Testing, Surge Clinic, and Respiratory Clinic](#)

Marshall opened a drive-through testing site at the hospital and a drive-through Respiratory Clinic in Cameron Park. People were able to quickly receive an exam, treatment and testing without having to leave their cars. These clinics served 40 to 50 people a day and assisted more than 1,000 people in FY21.

[COVID-19 Information Line](#)

Since December 2020, Marshall staff has answered more than 3,000 COVID-19 related calls and assisted people who did not need to visit the ED, freeing emergency care for those who experienced more severe COVID-19 symptoms, as well as anyone who needed emergency treatment.

[Senior Living Facilities](#)

In December 2020, the community saw a sharp rise in COVID-19 cases and an outbreak in all area senior living facilities (SLF). Marshall staff consulted with the facilities on their infection control practices to keep the virus out of those facilities. Marshall Strike teams tested and examined every patient and staff member in senior living homes. Staff also triaged residents to determine if people needed treatment in place, hospitalization, or hospice care. When only two hospital beds were available at the end of December, the Strike Team went out and tested and assessed more than 500 patients in 6 different senior living homes and treated some patients on site. That action decreased the number of people sent to the ED over successive months. A Senior Living Team was implemented in January 2021. The team circulated to SLF, providing testing and referrals. Over 400 vaccines were administered.

[Homeless Community](#)

Marshall took the lead in managing the COVID-19 response for the homeless in the community. That response was divided into three phases which included: (1) education and outreach, (2)

Project Roomkey to shelter medically vulnerable people in hotels and (3) assist people in obtaining basic necessities in order to find a permanent home and employment

COVID-19 Vaccinations

When the COVID-19 vaccine became available, the hospital vaccinated residents and staff in area senior living facilities. Additionally, Marshall sponsored drive-through vaccination clinics in Cameron Park, inoculating thousands of residents. Marshall also administered vaccines to employees' families in December 2020.

Response to the Caldor Fire

The Caldor Fire started on August 14, 2021 and became the 16th largest wildfire in California. Over more than two months, the blaze burned 221,835 acres. The fire displaced hundreds of residents and destroyed nearly 1,000 structures. Over 700 Marshall Medical Center employees were evacuated by the Caldor Fire, and at least four of them lost their homes.

When the Caldor Fire impacted the El Dorado County community and displaced residents, Marshall rerouted its services to evacuation shelters, offering medical care, consults and COVID-19 testing and vaccinations. After Barton Memorial Hospital was evacuated during the fire, Marshall was the only open hospital in El Dorado County. With a Community Outreach Team already in place visiting homeless sites, Marshall was able use that framework to regularly visit six evacuation sites to help evacuees with health concerns or serious conditions manage symptoms in place, preventing a visit to the ED or need to seek medical care.

Partnerships

Marshall has actively partnered with community organizations to improve the coordination of health and welfare services within the community. A partial list of partners includes: El Dorado County HHSA, Public Health, Behavioral Health and Library Services, Barton Health, El Dorado Community Health Center, Shingle Springs Health and Welfare Center, El Dorado County Sheriff's Department, Placerville Police Department, El Dorado County Board of Education, ACCEL, El Dorado Opportunity Knocks (El Dorado County Continuum of Care Agency), and a range of nongovernmental, nonprofit agencies.

Community Benefit Services Summary FY21

Accomplishments in FY21 (November 1, 2020– October 2021)

Community benefit services promote health and healing and are focused on addressing the identified unmet health needs of the community. For a program or service to be considered a community benefit it must: improve access to healthcare; or enhance the health of the community; or advance medical or healthcare knowledge; or reduce the burden of government or other nonprofit community efforts. Due to COVID-19, some programs and events were postponed. Other programs were transferred from in person events to virtual meetings to allow for social distancing.

Community Health Improvement Services

Definition: activities carried out to improve community health, available to the public, which address a community need.

Community Health Education

- Through a national program, Stop the Bleed, Marshall trained 20 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 FY21, Marshall staff instructors trained 570 El Dorado County residents, including students and teachers at local schools on wound packing and tourniquet application.
- Provided Alzheimer's disease and dementia workshops to community residents.
- Substance use and misuse education classes were provided to increase community knowledge and awareness of substance use issues in El Dorado County and to increase awareness of prevention and treatment services available in the community.
- Provided seniors presentations and screenings in areas of physical therapy, vestibular rehab, medication review, El Dorado County Services, blood pressure screenings, and a home safety review in partnership with nonprofit Safe-D, which helps eligible seniors properly equip their homes with assistive devices.
- 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.
- Supported the efforts of the local breastfeeding coalition by conducting a mini educational conference for participants.
- Provided tele-visits for Sweet Success, a gestational diabetes program. Participants learned about nutrition and meal planning, controlling blood sugar, exercise and emotional support resources.

- 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 at no charge to community members. In FY21, 451 residents were assisted remotely.
- Support groups were offered to community members through online options, including Zoom. The support groups included: breast cancer, ostomy, and prostate cancer.
- Tranquil Journeys provided meditation and relaxation sessions were offered virtually.
- *For Your HEALTH* is Marshall's quarterly magazine, widely distributed throughout El Dorado County and available in digital format on the hospital's website. Topics included: general wellness, vaccinations, and disease prevention.
- Provided free blood pressure and blood sugar health screenings, Body Analysis, and education at the Bob West Golf Tournament and the Placerville Lyon's Club.
- Provided Mental Health First Aid classes to 35 community residents This skills-based training course taught participants about mental health and substance use issues.

Community-Based Clinical Services

- The Community Care Network (CCN) provided care management support for homeless individuals and caregivers who struggled with managing family members with dementia in their homes. The team, which includes a pharmacist, medical social worker, RN case manager, LVN, and two resource specialists, served over 4,580 patients.
- Due to COVID, Marshall did not conduct annual flu shot clinics throughout the community, but provided flu vaccinations to patients in the primary care clinics.
- The Cancer Resource Center provided no-cost mammograms to 40 low-income women.
- The Congestive Heart Active Telephone Treatment (CHATT) program helped people manage congestive heart failure. The service included frequent telephone calls from a registered nurse, who specializes in cardiovascular care. CHATT served 337 individual patients.
- Care Coordination for Vulnerable Populations (CCVP) served the unsheltered/homeless, the elderly, women and Latino communities. Programs included a navigation program centered around life skills to decrease avoidable ED visits, decreasing missed medical appointments, and infection control. This work included the establishment of a Community Health Worker program. This program focused on working with volunteers who already engaged with the homeless population, and upskilled them to provide more expansive services. This group of skilled volunteers proved vital to the creation of capacity to support the significant and geographically scattered homeless population through the COVID crisis.
- Marshall Mobile Medicine/Rural Outreach's program 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.
- Multi-Visit Patients (MVP) identified the highest utilizers of the Emergency Department that could have been proactively managed at an outpatient/ community outreach capacity.
- 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.

Health Care Support Services

- The Cancer Resource Center provided transportation for 84 persons with cancer who had difficulty in accessing care. In addition, the hospital provided 81 gas cards.
- Provided information and referrals to community services.
- Offered assistance to enroll in public health insurance programs.
- Case Management and Social Services worked on behalf of homeless persons to assist with finding shelter, transportation, clothing and rehabilitation. The team assisted homeless persons to enroll in health insurance and free medication programs, and obtain needed medical equipment. In FY21, Marshall provided housing for eight vulnerable patients after discharge.

Health Professions Education

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

- Marshall educated clinicians on safe opioid prescribing, the value of MAT (Medication Assisted Treatment) and Harm Reduction.
- Marshall served as a health education training site for student precepting. The hospital worked with 120 students. The students were: Nurses, Medical and Clinical Lab Technicians, Pharmacology Students, Phlebotomists, Physical Therapists, and Paramedics.

Cash and In-Kind Donations

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

- The hospital provided in-kind donations of meeting space for a number of nonprofit organizations and community groups. Additionally, monetary contributions were made to nonprofit organizations that support community benefit efforts and address significant health needs in the community.
- Supported community organizations, including Relay for Life
- 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):
 - Access El Dorado ACCEL Steering Committee, a community safety net provider
 - El Dorado Community Health Clinic Board
 - El Dorado County Health Improvement Plan
 - El Dorado County Local Disaster Council
 - El Dorado Opportunity Knocks Continuum of Care
 - El Dorado EMS Joint Powers Authority
 - El Dorado County Economic Development Corporation
 - El Dorado Union High School District Career Technical Education Advisory Committee
 - Emergency Preparedness Coordinators Meeting
 - Leadership El Dorado
 - Multiple Casualty Incident Planning and Drills
 - Public Health Preparedness Work Group
 - American Hospital Association
 - California Hospital Association
 - California Association of Hospitals and Health Systems
 - Advisory Board
 - Assemblyman Kevin Kiley's Health Council on Homelessness and Mental 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.

In FY21, funding supported:

- Community benefit staff salary, benefits and expenses
- Administrative support

- Community benefit consultant

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

- The Marshall Education Department hosted job shadowing events for local students who were paired with Marshall employees to gain first-hand job experience in the health services field. 23 students participated and interacted with: diagnostic imaging, cardiology/pulmonology, clinical lab, cardiac Cath lab, ICU RN, physical therapist, monitor technician, respiratory therapy, and wound care RN.
- 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.
- Marshall supported *Opportunity Knocks*, a local organization that provided opportunities and resources for individuals with intellectual and developmental disabilities so they may pursue their educational, occupational and social interests.
- Marshall provided scholarships to area high school graduates to assist them in pursuing careers in healthcare.

Advocacy

Hospital representatives served on local, regional and state level organizations and committees that addressed community health improvement. Marshall 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.

Environmental Improvements

Marshall is a leader in “going green” with one of the largest solar programs for hospitals in the nation, and employed extensive recycling efforts to reduce water, waste and energy..

Financial Summary of Community Benefit

Marshall Medical Center community benefit funding for FY21 (November 1, 2020 to October 31, 2021) is summarized in the table below. The Hospital's community benefit costs comply with Internal Revenue Service instructions for Form 990 Schedule H. Expenses for "Health Care Services Rendered" were calculated using allocated cost from a cost accounting program.

Community Benefit Categories	Net Benefit
Financial Assistance (charity care) ¹	\$2,746,643
Unpaid Costs of Medi-Cal ²	\$13,500,992
Unpaid Costs of County Indigent Program ²	\$2,743
Education and Research ³	\$212,722
Other for the Broader Community ⁴	\$2,867,657
Total Community Benefit Provided Excluding Unpaid Costs of Medicare	\$19,330,757
Unpaid Costs of Medicare ²	\$38,973,809
Total Quantifiable Community Benefit	\$58,304,566

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 (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 FY22

Marshall continues to implement activities and programs to address the priority needs in our service area. Given the current unprecedented times as a result of COVID-19, Marshall anticipates some FY22 plans may be modified due to urgent community needs and situational restrictions that may limit how we are able to support the health and wellbeing of at-risk individuals and families in the hospital service area.

Significant Needs the Hospital Intends to Address

Marshall intends to take actions to address the following health needs identified in the FY19 CHNA and detailed in the FY20 – FY22 Implementation Strategy:

- Behavioral health (includes mental health and substance use)
- Chronic disease prevention, management, and treatment
- Support for the health and welfare of the community

Health Need: Behavioral Health

Strategy One

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

Actions

1. Marshall will strengthen partnerships with external entities, including El Dorado County, El Dorado Community Health Centers, the Shingle Springs Health and Wellness Center, law enforcement agencies and El Dorado County Emergency Medical Services, through consultation and coordinated services planning in order to expand the range of mental health and substance abuse prevention and treatment services, including providers with X-waivers.
2. Marshall will work with partners in the community to improve access to services for children, youth and adults with lower acuity behavioral health needs, including counseling and community assistance programs.
3. Marshall will optimize the use of its behavioral health specialists, including, but not limited to, social workers and clinical psychiatrists to expand the capacity to provide mental health services.
4. Marshall will improve the management of persons presenting in the ER with a mental health crisis by partnering with El Dorado County Mental Health services and law enforcement agencies, and adopting best-practice models of care for this population.
5. Marshall will explore the use of telehealth services to increase access to behavioral health services, including mental health and substance use services, both for crisis and ongoing care.

6. Marshall will designate a representative to participate in El Dorado County’s Community Health Improvement Plan team(s) to address mental health issues within El Dorado County.

Strategy Two

Impact substance use within El Dorado County.

Actions

1. Marshall will 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 external capacity to provide substance use prevention and treatment services, fill gaps in care and advance education.
2. Marshall will expand access to substance use management through Marshall CARES (Clinically Assisted Recovery & Education Services) to support treatment for persons with substance dependency and coordinate its approach with other agencies in the establishment and maintenance of care.
3. Marshall will build on the 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.
4. Marshall will 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 sustained engagement of persons in substance use management programs
5. Marshall will partner with community providers 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.
6. Marshall will 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.

Health Need: Chronic Disease Prevention, Management, and Treatment

Strategy One

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

Actions

1. Marshall will advance its support for population health management to optimize the health and wellbeing of our community through sustainable programs that promote health and coordinate care.
2. Marshall will expand preventive care and care management programs, in particular those identified to prevent chronic or debilitating conditions and promote health and wellbeing, and will continue to advance standardized best practices for identified disease management and treatment services and programs.
3. Marshall will expand its efforts to actively draw persons into preventive care and care management programs, and work with community partners to coordinate program delivery.
4. Marshall will continue the selective recruitment of providers identified to fill gaps in needed medical services, including physicians, advanced practice nurses and physician assistants, and Marshall will work with partners in the community to coordinate the delivery of these medical services between provider organizations.
5. Marshall will 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.
6. Marshall will 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, to track patient outcomes, support public health initiatives and improve performance among partners within El Dorado County.

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.

Actions

1. Marshall will actively work with partners in the community, including El Dorado County Health and Human Services, El Dorado Community Health Centers, Shingle Springs Health and Wellness Center, and El Dorado County Emergency Medical Services, to address gaps in care and to improve the coordination of services delivered
2. Marshall will work to support residents living healthy lives in the community, through improved transitions of care from the hospital, management of admissions and readmissions, connections to primary care, and access to social and disability support.

3. Marshall will 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.
4. Marshall will 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.
5. Marshall will work actively with partners, in particular El Dorado Opportunity Knocks (EDOK) Continuum of Care (CoC), 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.
6. Marshall will 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.

Health Need: Support for the Health and Welfare of our Community

Strategy One

Coordinate activities that positively impact persons with higher health needs.

Actions

1. Marshall will partner with community leaders and organizations, including Marshall Foundation for Community Health, El Dorado Community Foundation, El Dorado County and the City of Placerville, which have the ability to secure resources and the commitment to drive positive change for those with higher health needs.
2. Marshall will partner with community organizations to meet the needs of persons challenged to access appropriate care; in particular vulnerable populations including those with mental health issues, substance use issues, ethnic minority groups, those of lower socioeconomic status and the homeless.
3. Marshall will target outreach efforts toward high-need communities and vulnerable populations to improve access to care; in particular seniors, those with chronic conditions, mental health issues, substance use issues, ethnic minority groups, those of lower socioeconomic status and the homeless.
4. Marshall will 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.
5. Marshall will work with partners in the community to improve transitions of care and the coordination of service delivery to support residents to live healthy lives and remain safe at home.

6. Marshall will work with partners in the community to develop collaborative systems to share information to better coordinate service delivery to those in need, prevent individuals from 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.

Actions

1. Marshall will work with partners in the community to establish a culture of prevention within El Dorado County and will 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. Marshall will 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 external capacity to provide prevention and treatment services, fill gaps in care and advance education
3. Marshall will partner with El Dorado County's Community Health Improvement Plan teams, the Access El Dorado (ACCEL) collaborative and others to improve access to services for prevention, health and wellness.
4. Marshall will support development and/or expansion of care management services, including but not limited to the Community Care Network, Outpatient Care Management program, and Advanced Illness Management team in support of people living healthy lives in the community and reducing the avoidable need for acute care services.
5. Marshall will work with partners in the community to facilitate cultural sensitivity training that addresses stigmatized conditions such as behavioral health (including mental health and substance use), sexual orientation, age, socioeconomic status, weight management and homelessness.
6. Marshall will partner with community leaders and organizations, including Marshall Foundation for Community Health, El Dorado Community Foundation, El Dorado County and the City of Placerville, which have the ability to secure resources and the commitment to drive positive change for those with greater health needs.

Needs the Hospital Will Not Address

Taking existing hospital and community resources into consideration, Marshall Medical Center will not directly address the remaining health needs identified in the CHNA including: community safety, overweight and obesity, unintentional injuries, environmental pollution and food insecurity. Marshall chose to concentrate on those health needs that can most effectively be addressed, given the organization's capabilities. The hospital has insufficient resources to effectively address all the identified community needs and, in some cases, the needs are currently addressed by others in the community. Marshall will continue to look for opportunities to address community needs and provide assistance where we can make a meaningful contribution.

Evaluation of Impact

Marshall will monitor and evaluate the programs and activities outlined above. The reporting process includes collection and documentation of tracking measures, such as the number of people reached/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.

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