Annual Report and Plan for Community Benefit
Marshall Medical Center
Fiscal Year 2020 (November 1, 2019 - October 31, 2020)

Submitted to:
Office of Statewide Health Planning & Development
Healthcare Information Division
Accounting and Reporting Systems Section
Sacramento, California
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About Marshall Medical Center

Marshall’s History
In the late 1950s a group of local citizens saw a great need for improved healthcare 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 hard 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.

About Marshall
Marshall Medical Center (Marshall) is an independent, nonprofit community healthcare 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 125 beds (14 skilled nursing beds) located in Placerville; several outpatient facilities in Cameron Park, Placerville, El Dorado Hills and Georgetown; a group of primary care physicians, specialists; and many community health and education programs. Marshall has approximately 200 affiliated physicians and a team of more than 1,700 employees providing quality healthcare services to more than 150,000 residents of Western El Dorado County.

In FY2020, Marshall provided healthcare services for 4,768, patient admissions, 444 newborns, 132,222 outpatient visits and 28,338 emergency visits. At the Marshall Hospital, and other clinic campuses in Placerville, health services include:

- 111 Acute Inpatient Beds
- Birth Center
- Cardiac Rehabilitation
- Cardiac Services
- Cancer 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)
• Transitional Care (14 Skilled Nursing Beds)
• Wound Care

Awards
Marshall Medical Center was the recipient of a number of awards and accolades in FY2020:

● Joint Commission’s Gold Seal of Approval for Accreditation, a symbol of a healthcare organizations’ commitment to providing safe and quality patient care.
● BETA Healthcare Group, the largest professional liability insurer of hospitals on the West Coast, determined that Marshall met the requirements for Quest for Zero: Excellence in Emergency Department and Obstetrics, demonstrating a commitment to continuous improvement in striving to eliminate preventable harm to those in need of emergent care.
● Marshall Medical Center’s Emergency Department was recognized by the 2020 Guardian of Excellence Award by Press Ganey, a national healthcare performance improvement organization.
● Named by California Health and Human Services, along with Cal Hospital Compare, for excellence in Patient Care and Safety.
● Leapfrog Hospital Safety Grade “A” for Fall 2020
● 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 Redesignated birth facility by Baby-Friendly USA in FY2020.
● Nationally ranked #2 out of 3,282 hospitals by the Lown Institution for recognition in Patient Outcomes, Value of Care and Civic Leadership.
Vision
We are a cohesive healthcare 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 sixty years, Marshall has worked to promote the community’s health and wellbeing and comparably, El Dorado County is thriving. 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 healthcare 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

<table>
<thead>
<tr>
<th>Geographic Area</th>
<th>ZIP Code</th>
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<tbody>
<tr>
<td>Cool</td>
<td>95614</td>
</tr>
<tr>
<td>Diamond Springs</td>
<td>95619</td>
</tr>
<tr>
<td>Kingsville/Nashville</td>
<td>95623</td>
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<tr>
<td>Garden Valley</td>
<td>95633</td>
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<tr>
<td>Georgetown</td>
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<tr>
<td>Greenwood</td>
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<tr>
<td>Grizzly Flats</td>
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<td>Lotus</td>
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<td>Pilot Hill</td>
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<tr>
<td>Placerville</td>
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<tr>
<td>Rescue</td>
<td>95672</td>
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<tr>
<td>River Pines</td>
<td>95675</td>
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<td>Shingle Springs/Cameron Park</td>
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<tr>
<td>Somerset</td>
<td>95684</td>
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<tr>
<td>Camino/Apple Hill</td>
<td>95709</td>
</tr>
<tr>
<td>Pollock Pines</td>
<td>95726</td>
</tr>
<tr>
<td>El Dorado Hills</td>
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</tbody>
</table>
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%). Additionally, Veterans compose 10.2% of the civilian population, which is higher than the county (9.8%) and the state (5.6%).

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 Marshall 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, healthcare 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 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.

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 healthcare 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

Marshall Medical Center FY2020 Community Benefit Report and Plan
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.aspx. 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 FY2020, Marshall engaged in activities and programs that addressed the priority health needs identified in the 2020 - 2022 Implementation Strategy/Community Benefit Plan. 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 our 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. Among adults in El Dorado County, 7.9% were determined to have likely experienced serious psychological distress in the past year. Serious psychological distress was experienced in the past year by 17.4% of area teens, which was higher than the state level (10%). 14% of adults smoked cigarettes and the rate of hospitalizations and Emergency Room visits for opioid use in El Dorado County exceeded state rates.

Response to Need

- Marshall CARES (Clinically Assisted Recovery & Education Services) was created to support treatment for persons with substance dependency, including alcohol, tobacco, stimulants, opioids, benzodiazepines and other sedative hypnotics. Clinic services included comprehensive medication assisted treatment with a physician, counseling, case management and behavioral health. In FY2020, the CARES team:
  - Participated in the Opioid Coalition Meetings.
  - Collaborated with a Behavioral Health Clinician at Shingles 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 that 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.

- Received approval in FY20 to begin contingency management services in FY21. Contingency Management is an evidence-based strategy specifically used to help people with stimulant use disorder. Marshall CARES plans to implement these services in FY2021.
- Utilized Substance Use Navigators, located in the hospital emergency department and supporting 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.

- Since December 2016, Marshall has participated in a joint effort with the El Dorado Community Health Center (EDCHC) and the California Healthcare Foundation in an effort to move people through 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 a prescription of buprenorphine to alleviate withdrawal symptoms. They are also referred to outpatient therapy, through the EDCHC and Marshall CARES, where they meet with a doctor within 48 hours. The robust program includes group sessions, counseling, and social services. Because of this participation and success rate, Marshall was recognized as a star site in California and is being 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).
- Provided presentations and training on Medication Assisted Training and Harm Reduction.
- In FY2020, Marshall Foundation for Community Health provided funding to agencies and organizations focused on 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. In Marshall’s service
area, 10.2% of adults have been diagnosed with heart disease, which is higher than the state (6.2%). In El Dorado County, cancer rates are higher overall than at the state level.

Response to Need

- Marshall’s Community Care Network (CCN), focuses on improving the effectiveness and quality of care for high-risk patients. CCN was developed to help people coordinate their healthcare in the community by providing in-home and telephonic support services. The team assists persons recently discharged from the hospital to navigate through the challenges of the healthcare system, making sure that they have ongoing education about their health, ensuring satisfaction of services and providing support while valuing individual physical and mental well-being. This program works to reduce 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 FY2020, 207 persons were reached through CCN.

- The Congestive Heart Active Telephone Treatment (CHATT) program helps people manage congestive heart failure. CHATT improves quality of life, reduces CHF complications and helps keep people with CHF out of the hospital. This service includes frequent telephone calls from a registered nurse, who specializes in cardiovascular care. In FY2020, CHATT served 633 individual patients and an average of 184 patients each month.

- In FY2020, as part of Marshall’s Quality Improvement Project: Colorectal Cancer Screening, 600 FIT kits were sent to primary care patients, between the ages of 50 and 64, who had no record of any kind of colorectal cancer screening.

- The Cancer Resource Center supported over 500 persons with cancer and their families through patient navigation, education, support groups, social services and emotional support. They provided support groups for persons with breast cancer, prostate cancer and ostomies. A Look Good Feel Better class was provided on line and reached 7 women. The Wig Bank served 28 persons.

- The Cancer Resource Center provided 25 no-cost mammograms and offered transportation assistance to persons with cancer by providing them with 177 rides.

- In FY2020, Marshall hosted or participated in the following activities:
  - Joint replacement education
  - Stroke education
  - Healthy Babies/lactation classes
Support for the Health and Welfare of our 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 healthcare 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) is an expansive, interdisciplinary program led by Marshall Medical Center, strategically reaching the most vulnerable populations in El Dorado County. This navigation support program reached 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.

- At the beginning of the COVID crisis, in March 2020, Marshall volunteered its support to the County of El Dorado to lead its Homeless Community Action Team. The focus was to coordinate the activities of county and nonprofit and volunteer agencies including, case management, housing, health providers, law enforcement and social services. The objective was to manage the risks COVID-19 faced by the homeless and unsheltered populations of the County. Initially, this involved outreach programs to reinforce the importance of hygiene, masking and social distancing, then expanded into establishing project RoomKey within the County. RoomKey provided contracting for dedicated motel accommodation and the identification and selection on the most medically vulnerable individuals for placement. Vaccination of this population was also a focused activity. Importantly, these activities created a model for supporting the homeless population within the County. Engagement, health services, navigation services and transition to interim housing will endure beyond the COVID crisis. As a result, El Dorado County will have established a whole new approach to supporting the homeless population, which prior to COVID, has experienced noticeable resistance.

- Marshall implemented a standard process to ensure that patients discharged from the hospital have an appointment with a primary care provider for follow up. In FY2020, 99% of patients discharged from the hospital had a follow-up appointment scheduled.

- Marshall’s 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.
• Marshall Hospital participated in the ACCEL (Access El Dorado) Provider Capacity meetings. ACCEL is a safety net provider network of multiple healthcare agencies in El Dorado County. ACCEL’s work on care pathway development included a referral pathway for primary care providers to refer appropriate patients for pediatric mental health services. ACCEL also helped the Opioid Coalition to focus on solutions to this issue in El Dorado County.
• Marshall’s Community Care Network (CCN) assisted in breaking down barriers to healthcare (i.e., transportation, heating, caregiver assistance, fall risk, emotional support).
• In FY2020, Marshall developed a Performance Improvement program focused on Medicare annual wellness visits. COVID-19 has pushed the roll-out time of the pilot to all providers to FY2021.
• Marshall Mobile Medicine/Rural Outreach 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. In FY202, over 1,420 people were served.
  ○ Multi-Visit Patients (MVP) identified the highest utilizers of the Emergency Department that could have been proactively managed in an outpatient/community outreach capacity. In FY2020, 758 patients were assisted.
  ○ Clinical services were provided at Library Hubs on library campuses throughout the county.
  ○ Working with a variety of community partners who support low income and unsheltered individuals, the outreach program provided wound care, supported medication adherence, took vital signs, provided referrals and health education, assisted clients with making calls, established primary and specialty care appointments, assisted with completion of health insurance coverage documents, and offered psychiatric support. In FY2020, 15 volunteers were trained in the navigation for vulnerable populations program.

Marshall Medical Center’s COVID-19 Response
Marshall Medical Center took a myriad approach to preparedness for the pandemic:
• Staff prepared for supervised home management of and recovery from viral pneumonia.
• Practitioners established a 24/7 telephone triage line to screen patient calls related to chronic conditions as well as COVID-19 questions and follow-up.
• The Emergency Department established a drive-through Emergency Department triage and testing site.
• Staff proactively developed telephone pre-visits for patients who needed prescriptions refills or routine lab work so patients did not have to come into the clinics for care.
• Practitioners implemented telephone visits and virtual visits.
• The Ethics committee reviewed related policies, such as triage, resuscitation, and physician orders for life-sustaining treatment (POLST).
• The Chief Wellness Officer and the Care for the Caregiver Committee developed plans to mitigate stress and emotional burdens and to support Marshall providers and staff.
• Marshall provided community education about shelter-in-place orders and preventive measures, including:
  o Banners, digital signs and bus shelter posters
  o Public service announcement shared on social media
  o Outreach to local senior housing and skilled nursing facilities to provide on-site medical screenings and support
  o Implemented outreach and sheltering to homeless populations
• Marshall launched the program COVID Catch-up to proactively remind residents about critical screening exams that may have been delayed due to the pandemic. Reminders were sent for mammograms, CRCS and Fit kits, annual wellness checks, gynecological exams, and diabetes management visits.

Marshall Medical Center’s response to the pandemic is documented in Members in Action Case Study: Four Stages of Planning and Implementation During Covid-19: One Rural Hospital’s Preparations, Marshall Medical Center, Placerville, CA. You can access the American Hospital Association April 2020 Case Study here.
Community Benefit Services Summary FY2020

Accomplishments in FY2020 (November 1, 2019– October 2020)
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 of our annually supported 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 on how to treat injuries caused by home accidents, motor vehicle accidents, active shooters, bombings, and work-related injuries, among others. In FY2020, Marshall staff instructors trained 112 El Dorado County residents, including students and teachers at local schools on wound packing and tourniquet application.
- Substance use and misuse education classes were provided to increase community knowledge and awareness of substances use issues in El Dorado County and to increase awareness of prevention and treatment services available in the community.
- Marshall supported collaborative disease prevention and health education efforts within the community including women’s health events and youth programs.
- Marshall provided free or low-cost educational classes to the community, including childbirth classes to help expectant mothers take better care of themselves and their children. Class topics included healthy pregnancy, breastfeeding, and nutrition. Many classes were offered via Livestream and pre-recorded video due to COVID-19.
- Marshall supported the efforts of the local breastfeeding coalition by conducting a mini educational conference for participants.
- In FY2020, Marshall provided 427 no charge “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 including books, DVDs, CDs, and medical journals, 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 FY2020, 672 patrons were served.

- Support groups were offered to community members through online options, including Zoom. The support groups included: breast cancer, ostomy, and prostate cancer.
- Marshall’s Tranquil Journeys provides programs for persons with cancer. In FY2020, meditation and relaxation sessions were offered virtually. Over 200 individuals were served.
- Marshall clinicians conducted targeted outreach efforts to high-needs communities and populations, with an emphasis on substance use and misuse, withdrawal, and community support services.
- 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.
- Marshall 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 in FY2020.

Community-Based Clinical Services

- Marshall’s Community Care Network (CCN) served over 200 patients in FY2020. CCN provided care management support for homeless individuals and caregivers that struggled with managing family with dementia in their homes. The team, which includes a pharmacist, medical social worker, RN case manager, LVN, and two resource specialists, made 16,080 calls and home visits in FY2020.
- 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.
- Marshall’s Cancer Resource Center provided no-cost mammograms to 25 low-income women.
- The Congestive Heart Active Telephone Treatment (CHATT) program helps people manage congestive heart failure. CHATT improves quality of life, reduces CHF complications and helps keep people with CHF out of the hospital. This service includes frequent telephone calls from a registered nurse, who specializes in cardiovascular care. In FY2020, CHATT served 633 individual patients and an average of 184 patients each month.
- 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, built on a model created by Sacramento State
University. 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. In FY202, over 1,420 people were served.
  - Multi-Visit Patients (MVP) identified the highest utilizers of the Emergency Department that could have been proactively managed at an outpatient/community outreach capacity. In FY2020, 758 patients were assisted.
  - 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.

Healthcare Support Services

- Marshall’s Cancer Resource Center provided 177 transportation rides for persons with cancer who had difficulty in accessing care. In addition, the hospital provided transportation assistance for over 350 persons.

- In 2018, Marshall’s Clinically Assisted Recovery and Education Services (CARES) clinic opened, utilizing Medication Assisted Treatment (MAT) as a core intervention. In 2019, Marshall expanded MAT services to Divide Wellness Center Clinic in Georgetown to reach more community members. In FY2020, the number of participants in the MAT/ED Bridge program was 426.

- Marshall provided information and referrals to community services.

- The hospital offered assistance to enroll in public health insurance programs.

- Marshall’s 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 FY2020, Marshall provided housing for 8 vulnerable patients after discharge.
• Marshall worked with local agencies for disaster and public health emergencies in FY2020. The preparedness included participation in drills and exercises, as well as multiple casualty incident planning.

• In FY2020, as part of Marshall’s Quality Improvement Project: Colorectal Cancer Screening, 600 FIT kits were sent to primary care patients, between the ages of 50 and 64, who had no record of any kind of colorectal cancer screening.

**Health Professions Education**

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

• Marshall educated clinicians on safe opioid prescribing and the value of MAT (Medication Assisted Treatment), and Harm Reduction with department presentations.

• Marshall served as a health education training site for student precepting. The hospital worked with 94 students. The students were: Nurses, Lab Technicians, Pharmacology Students, Radiology Technicians, Phlebotomists, 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.

• 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 Opportunity Knocks Continuum of Care
  - El Dorado EMS Joint Powers Authority
  - El Dorado County Economic Development Corporation
  - Leadership El Dorado
  - American Hospital Association
  - California Hospital Association
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 FY2020, funding supported:
• Community benefit staff salary, benefits and expenses
• Administrative support
• 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
• 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. 12 students participated in FY2020 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.

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 FY2020 (November 1, 2019 to October 31, 2020) 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.

<table>
<thead>
<tr>
<th>Community Benefit Categories</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assistance (charity care)(^1)</td>
<td>$2,542,303</td>
</tr>
<tr>
<td>Unpaid Costs of Medi-Cal(^2)</td>
<td>$27,129,612</td>
</tr>
<tr>
<td>Unpaid Costs of County Indigent Program(^2)</td>
<td>$6,290</td>
</tr>
<tr>
<td>Education and Research(^3)</td>
<td>$180,252</td>
</tr>
<tr>
<td>Other for the Broader Community(^4)</td>
<td>$3,231,231</td>
</tr>
<tr>
<td><strong>Total Community Benefit Provided Excluding Unpaid Costs of Medicare</strong></td>
<td><strong>$33,089,688</strong></td>
</tr>
<tr>
<td>Unpaid Costs of Medicare(^2)</td>
<td>$39,660,081</td>
</tr>
<tr>
<td><strong>Total Quantifiable Community Benefit</strong></td>
<td><strong>$72,749,769</strong></td>
</tr>
</tbody>
</table>

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\(^1\) 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 FY2021

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 FY2021 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 FY2019 CHNA and detailed in the FY2020 – FY2022 Implementation Strategy:

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

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