



**Annual Report and Plan for Community Benefit  
Marshall Medical Center**

**Fiscal Year 2019 (November 1, 2018 - October 31, 2019)**

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

**Contents**

About Marshall Medical Center .....3

Mission, Values and Principles .....6

    Vision Statement .....6

    Mission .....6

    Values and Principles .....6

Caring for Our Community .....8

    Service Area .....8

    Community Snapshot .....9

Addressing Priority Health Needs ..... 10

Community Benefit Services Summary FY2019 ..... 15

Financial Summary of Community Benefit..... 19

Community Health Needs Assessment.....20

Community Benefit Plan FY2020 – FY2022.....22

    Significant Needs the Hospital Intends to Address .....22

    Needs the Hospital Will Not Address .....26

    Evaluation of Impact .....26

Contact Information .....28

## About Marshall Medical Center

### Marshall's History

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 were 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.

### Marshall Facts

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 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 health care services to more than 150,000 residents of Western El Dorado County.

In 2019, Marshall provided health care services for 458 newborns, 142,352 outpatient visits and 26,993 emergency visits. At the Marshall Hospital campus in Placerville, health services include:

- 111 Acute Inpatient Beds
- Birth Center
- Cardiac Rehabilitation
- Cardiac Services
- Diagnostic Imaging Services
- Emergency Department
- Intensive Care/Critical Care Unit
- Laboratory
- Outpatient Occupational Therapy
- Outpatient Physical Rehabilitation
- Outpatient Speech Therapy
- Palliative Care
- Respiratory Care
- Surgery (Outpatient/Inpatient)
- Transitional Care (14 Skilled Nursing Beds)

- Wound Care

Marshall's Emergency Department is a verified Level III Trauma Center and the Stroke Program is distinguished as a Primary Stroke Center by the Joint Commission and earned a Gold-Plus designation from the American Heart/American Stroke Association. Marshall's Birth Center was designated by the World Health Organization and UNICEF as a Baby Friendly® certified facility for breastfeeding advocacy. Additionally, Marshall Medical Center is the recipient of Healthgrades Outstanding Patient Experience Award and was distinguished as one of the Sacramento Region's Best Places to Work by the *Sacramento Business Journal*.

Marshall Medical Center was the recipient of the following awards and accolades in 2019:

- 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, chosen by the Public Health Institute (PHI) and funded through the Substance Abuse and Mental Health Services Administration (SAMHSA).

Marshall has a strong commitment to providing the necessary health services and facilities to support the surrounding community, including:

### **Placerville**

- Addiction Medicine
- Cardiology Services
- Ear, Nose and Throat
- Family and Internal Medicine
- General Surgery
- Health Education
- Hearing Center
- Homecare
- Laboratory
- OB/GYN
- Orthopedics
- Pediatrics
- Pulmonology
- Urology

### **Georgetown**

- Divide Wellness Center

**Cameron Park**

- Cancer Resource Center
- Cardiology
- Community Health Library
- Diabetes and Nutrition Education
- Diagnostic Imaging
- Family and Internal Medicine
- Gastroenterology
- General Surgery
- Hearing Center
- Hematology/ Oncology
- Infusion Center
- Laboratory
- Nephrology
- OB/GYN
- Outpatient Surgery
- Podiatry
- Psychiatry
- Rheumatology
- Urology

**El Dorado Hills**

- Cardiology
- Family Medicine
- Laboratory
- Orthopedics and Sports Medicine
- Physical and Speech Therapy

## Mission, Values and Principles

### Vision Statement

Transforming health care for you through compassion, quality and innovation.

### 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 health 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 and Principles

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 and principles:

- **Our patients come first.** All other values are overshadowed by the proper care of those who entrust their lives to us. We embrace the diversity of our community and it is our privilege to partner with our patients in their health and to treat them with respect and compassion.
- **Healing is an art.** Medicine flourishes best in a healing environment. Our patients and their families are an essential part of the health care team. We recognize each patient is an individual and we adapt care to their personal needs. To enrich our healing environment, members of the Marshall community treat each other with the same respect we hold for our patients.
- **Medicine is a science.** Clinical care provided at Marshall is based on the application of nationally recognized best practices. We strive for continued improvement in all aspects of patient care, pursuing growth in our collective expertise. Excellence in prevention, diagnosis and treatment of disease are defined by documented clinical outcomes.
- **Our organization is not defined by walls.** Our organization is defined by the doors we open. The community is best served by a continuum of care, wherever those services are needed, meeting patients wherever they are in the spectrum of health. We reach out to emphasize primary care, prevention, education, research, and collaboration with other organizations when their missions complement our own.

- **We bequeath Marshall to future generations.** Our community is best served by organizations that are locally owned and managed. To maintain our independence and meet the present and future needs of the community, we manage Marshall's finances carefully. We strive to provide the highest quality of care while maintaining exceptional value and unparalleled service.

## 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. Marshall provides financial assistance to 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 health.

## Service Area

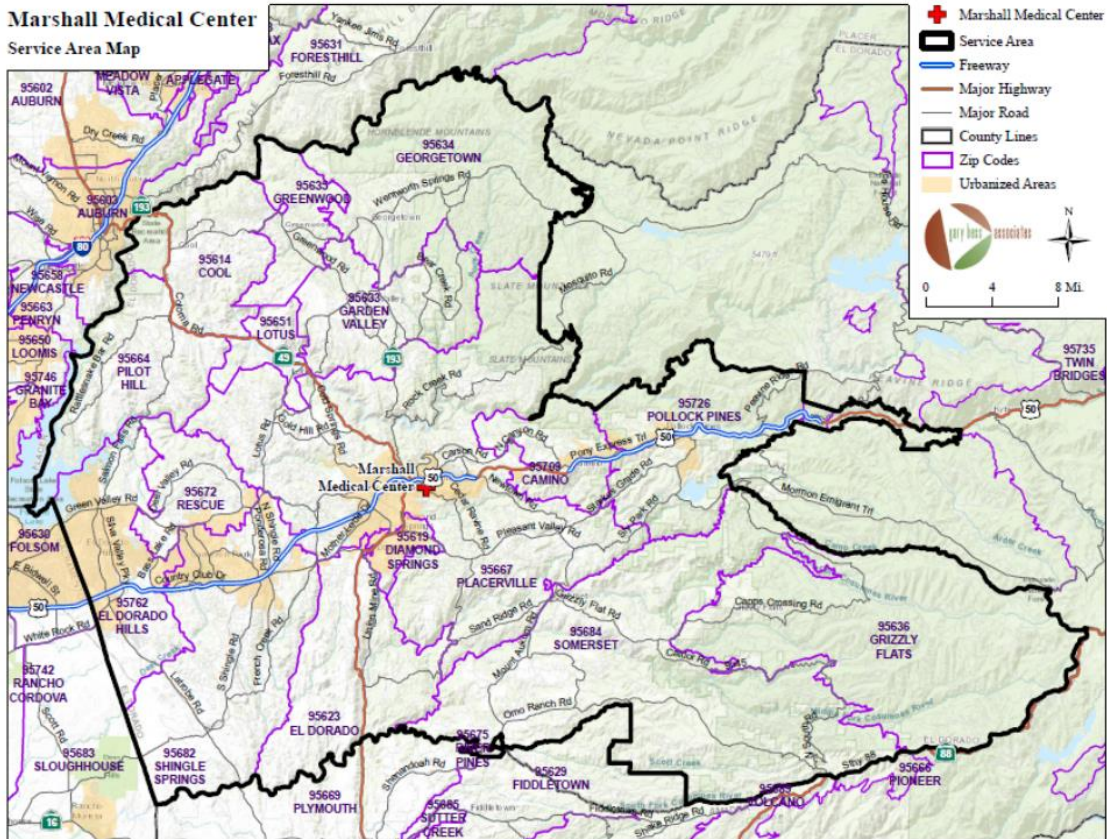
Marshall Medical Center is located at 1100 Marshall Way, Placerville, California, 95667. The service area includes 17 ZIP Codes, representing cities or communities in El Dorado County and Amador County (River Pines). The Marshall Medical Center service area is presented below by community and ZIP Code 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



## Map of the Marshall Medical Center Service Area



### 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 service area population, 59.3% are adults, and 19.6% are seniors. 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 at or below 100% of the federal poverty level (FPL) and 21.1% are 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. This level of education is higher than the state rate.

## Addressing Priority Health Needs

In FY2019, Marshall engaged in activities and programs that addressed the priority health needs identified in the 2016-2019 Implementation Strategy/Community Benefit Plan. 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)

#### Response to Need

- Marshall began recruiting for a psychiatrist and licensed clinical social workers in 2016. After an exhaustive search, a psychiatrist was hired and began work in September 2017, seeing patients referred by Marshall primary care providers. Marshall successfully recruited a second psychiatrist who started in September, 2019.
- 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 include comprehensive medication assisted treatment with a physician, counseling, case management and behavioral health.
- 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 a person presents in Marshall's Emergency Department in withdrawal, he/she is offered participation in the MAT/ED Bridge program, which includes a prescription of buprenorphine to alleviate withdrawal symptoms. He/she is 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, in 2019 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.

	2016 Baseline	2017	2018	2019
Number of participants in Marshall's MAT/ED Bridge program	0	31	67	338
ED Visits and hospitalizations related to mental health	22%	18%	19%	21%
Rate of patients served within 30 days of receiving a non-emergency referral from a Marshall PCP to a Marshall mental health provider	0	23%	16%	17%

- As part of the ED Bridge Medication Assisted Treatment program, 12 Marshall physicians completed an eight-hour training to qualify for a waiver to prescribe and dispense buprenorphine.
- Beginning April 2018, Loni Jay, MD, Marshall Sierra Primary Medicine physician, began taking ED follow up patients from the ED Bridge program. By October, Dr. Jay's practice became a half-time addiction medicine practice and in 2019, she transitioned to full time practice at Marshall CARES. The CARES program is moving toward expansion with another provider at Marshall's Georgetown Divide Wellness Center.
- 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).
- Cindy Rice, RN, Marshall's VP of Clinical Nursing Services; Larry Schmidt, RN, Emergency Services Director and Michael Mirhadi, MD, Director of Emergency Medicine, held monthly meetings with El Dorado County Public Health and leadership from Telecare, who runs the Psychiatric Healthcare Facility. They discussed and assessed process, handoffs, and defined working relationships to improve continuity among the three entities.
- Presentations and training on Medication Assisted Training and Harm Reduction were provided.
- In 2019, Eric Hill was hired as the Substance Use Navigator to educate CARES patients on resources available for treatment, and help them navigate the health care system to receive follow up visits. He also conducted outreach to people coming in through the ED Bridge program at Marshall's Emergency Department.
- Marshall staff participated with the El Dorado County Sheriff's Department, ACCEL, El Dorado County Opioid Coalition, El Dorado Community Health, and El Dorado County Substance Use Disorder Services to provide medical and education services with the Homeless Outreach Team in Placerville. Joshua Clark, Marshall CARES Program Manager, also provided quarterly education sessions.
- In 2019, Marshall Foundation for Community Health provided funding to the following agencies and organizations:
  - El Dorado County Health and Human Services: Purchased Botivin Module on Life Skills Drug Abuse Prevention to educate schools and community on opioid abuse and misuse.
  - Every 15 Minutes Program: Funded the program through El Dorado County Emergency Services to provide the national program to Ponderosa High School Junior and Seniors on the effects of driving under the influence.
  - Marshall CARES: Provided gap coverage for patients to receive Buprenorphine.

- Sierra Health Reduction Coalition: The Foundation became fiscal sponsor to this organization that educates and helps those using opioids.

## **Disease Prevention, Management and Treatment**

### **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 health care 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 health care 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 2019, 2,137 persons were reached through the CCN. Rates of hospital admissions and readmissions for persons enrolled in CCN showed significant reductions in hospital utilization when comparing monthly averages after enrollment to monthly averages for the 12-month period prior to their enrollment (baseline period). In 2019, 12 % of persons in CCN had an ED visit for routine care. This is considerably lower than the overall ED rate of 29% for routine care visits.
- 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 2019, CHATT served 361 patients.
- The Cancer Resource Center supported 350 persons with cancer in 2019 through patient navigation, education, support groups, social services and emotional support. The Cancer Resource Center provided 33 no-cost mammograms and offered transportation assistance to persons with cancer by providing with 282 rides.
- In 2019, Marshall hosted or participated in the following activities:
  - Employee Health Fairs
  - Free FIT Testing for colon cancer
  - Flu Shot Clinics
  - Women's Health Screenings
  - Affair of the Heart cardiology/health screenings
  - Fall Prevention education and workshops

- Stroke Education
- Healthy Babies/lactation classes
- Cancer Education
- Low cost/no cost mammograms

### **Access to High Quality Health Care and Services Response to Need**

- In 2019, Marshall hired two pediatric and four family medicine providers to replace providers who have left and augment existing services.
- 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 2019, 99% of Marshall 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 insurance coverage and free medication programs and obtain needed medical equipment.
- Marshall’s Chief Nursing Officer, Kathy Krejci, RN, served on the board of the El Dorado Community Health Center, lending guidance, expertise and insight into linkages with Marshall’s medical resources.
- Marshall’s Chief Executive Officer, James Whipple, served as an advisor to the El Dorado County Health Improvement Plan, offering input and insight into improving public health in the county.
- Marshall’s Chief Operating Officer, Shannon Truesdell, RN, served on the board of ACCEL (Access El Dorado) Steering Committee, a safety net provider network of multiple health care agencies in El Dorado County. Maia Schneider, Marshall’s Executive Director of Business Development, served as an alternate representative on the committee. 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 incubated the grant-funded Opioid Coalition to focus on solutions to this issue in El Dorado County.
- Marshall’s Business Development Executive Director, Maia Schneider, attended ACCEL meetings with elected officials to improve community health. Together with CEO James Whipple, meetings were held with:
  - District 3 Supervisor Brian Veerkamp
  - District 4 Supervisor Lori Parlin
  - Assemblyman Kevin Kiley and his health council
  - Congressman Tom McClintock
  - Assemblyman Frank Bigelow

- Marshall's Business Development Executive Director, Maia Schneider, served on the Board of the El Dorado County Joint Powers Authority for Emergency Medical Services.
- Marshall's Community Care Network assisted in breaking down the barriers to health care (i.e., transportation, heating, caregiver assistance, fall risk, emotional support).
- In 2019, 99% of Marshall staff completed the online course "Diversity in Healthcare."

## Community Benefit Services Summary FY2019

### Accomplishments in FY2019 (November 1, 2018 – October 2019)

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 health care; or enhance the health of the community; or advance medical or health care knowledge; or reduce the burden of government or other nonprofit community efforts.

### 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 22 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. To date, Marshall staff instructors have trained 229 El Dorado County residents, including students and teachers at local schools.
- Continuous substance use and misuse education classes were provided throughout the community 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's annual Women's Health Expo featured health talks by medical experts, a 5k run/walk and free health screenings by Marshall clinicians.
- 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 Sweet Success, a gestational diabetes program.
- Marshall's Community Health Library contains over 5,000 resources including books, DVDs, CDs, and medical journals, which are made available at no charge for use by community residents. Staff librarians also conducted medical topic searches at no charge to community members.
- Support groups were offered to community members. The support groups included: amputees caring together, bereavement, bipolar insights, cancer, family care, survivors of suicide victims, Multiple Sclerosis, Parkinson's disease, spinal cord injuries, and surviving sudden loss.
- Health-related classes were offered to the community including smoking cessation,

stroke education, Advance Directives and POLST (Physician Orders for Life-Sustaining Treatment) Workshops.

- Marshall's Tranquil Journeys provides programs for persons with cancer. In 2019, Reiki instructors helped participants explore self-help stress reduction methods such as acupressure, energy healing, guided imagery, poetry, mantras and Tibetan Singing Bowls.
- Matter of Balance Fall Prevention Class is an 8-week workshop that helped participants gain confidence, reduce fear of falling and learn exercises and strategies to help prevent falls, free for those 60 years and older.
- 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.
- Bipolar Insights community classes addressed self-medicating, illegal drug use and problems with drug addiction.
- Marshall's Cancer Resource Center hosted art therapy and exercise programs free of cost for persons with cancer.
- *For Your HEALTH* is Marshall's quarterly magazine, widely distributed throughout El Dorado County and available in digital format on the hospital's website. Recent topics include general wellness, nutrition, and disease prevention topics.

#### Community-Based Clinical Services

- During Marshall's Fall Prevention Event, medical staff screened community members for issues that may contribute to a fall including: vision screening, fitness screening, blood pressure screening and vertigo assessments. Participants spoke to a pharmacist for a review of their medications and obtained information on home safety. Additionally, community members were educated on balance and strength.
- Marshall provided head and neck cancer screenings and prevention education.
- Affair of the Heart is an annual cardiology department event featuring heart related health screenings.
- Marshall conducted annual flu shot clinics throughout the community.
- Free FIT testing for colon cancer was made available to the public.
- Marshall's Cancer Resource Center provided no-cost mammograms to 33 women.

#### Health Care Support Services

- Marshall's Cancer Resource Center provided 282 transportation rides for persons with cancer. In addition, the hospital provided transportation assistance for over 300 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 2019, the number of participants in the MAT/ED Bridge program was 338, up from 67 in 2018.

- Marshall provided information and referrals to community services.
- The hospital offered assistance to enroll in public health insurance programs.

### **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.
- Marshall's rural, evidence-based, patient-centered approach to addiction, the ED Bridge MAT program, is a national model. In FY2019, Marshall clinicians presented program insights at national conferences including:
  - AMERSA (Association for Multidisciplinary Education and Research in Substance use and Addiction)
  - CHA (California Hospital Association) Behavioral Health Symposium
  - PHI (Public Health Institute) National Opioid Leadership Summit with the US Surgeon General
  - CAPA (California Academy of Physician Assistants)
- As part of the ED Bridge Medication Assisted Treatment program, 12 physicians completed 8-hour training to qualify for a waiver to prescribe and dispense buprenorphine.
- Marshall served as a health education training site for student precepting. The hospital worked with 154 students. The students were: Nurse Practitioners, Physician Assistants, Respiratory Therapists, Lab Technicians, Medical Assistants, Pharmacology Students, Diagnostic Imaging Students, Registered Nurses, and Physical Therapy Students.

### **Cash and In-Kind Donations**

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

- Donations were provided to health care organization and to non-profit community organizations that addressed community benefit health priorities.
- 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:
  - Access El Dorado ACCEL Steering Committee, a community safety net provider
  - Behavioral Health Collaborative

- Chronic Disease Coalition
- El Dorado Community Health Center
- El Dorado County for Creation of Western Slope Mental Health Collaborative
- El Dorado County Health Improvement Plan
- El Dorado County Joint Powers Authority for Emergency Medical Services
- El Dorado County Opioid Coalition
- El Dorado Opportunity Knocks Continuum of Care
- MAST (Multi-disciplinary Adult Services Team)
- Point-in-Time Count of Homeless Population

### **Community Benefit Operations**

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

- 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.
- Medical Center staff worked with local ROPs (Regional Occupational Programs) to provide students with on-the-job training.
- Marshall hosted an annual Health Career Exploration Day for local high school students.

#### Coalition Building and Advocacy

Hospital representatives served on a number of local, regional and state level organizations and committees that address community health improvement. Marshall engaged in advocacy efforts that supported the community.

#### 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 FY2019 (November 1, 2018 to October 31, 2019) is summarized in the table below. The hospital's community benefit costs are in compliance with Internal Revenue Service instructions for Form 990 Schedule H. All community benefit expenses are based on actual costs, not charges, in compliance with IRS Form 990 Schedule H instructions.

Community Benefit Categories	Net Benefit
Charity Care/Financial Assistance <sup>1</sup>	\$2,421,410
Unpaid Costs of Medi-Cal <sup>2</sup>	\$26,283,571
Others for the Economically Disadvantaged <sup>3</sup>	\$142,835
Education and Research <sup>4</sup>	\$207,818
Other for the Broader Community <sup>5</sup>	\$3,436,211
<b>Total Community Benefit Provided Excluding Unpaid Costs of Medicare</b>	<b>\$32,491,845</b>
Unpaid Costs of Medicare <sup>2</sup>	\$34,427,970
<b>Total Quantifiable Community Benefit</b>	<b>\$66,919,815</b>

<sup>1</sup> Financial Assistance includes traditional charity care write-offs to eligible patients at reduced or no cost based on the individual patient's financial situation. Financial Assistance or Charity Care does not include costs for patients who had commercial insurance, but could not afford their out of pocket costs.

<sup>2</sup> Unpaid costs of public programs include the difference between costs to provide a service and the rate at which the hospital is reimbursed.

<sup>3</sup> Includes other payors for which the hospital receives little or no reimbursement (e.g. County indigent).

<sup>4</sup> Costs related to the health professions education programs and medical research that the hospital sponsors.

<sup>5</sup> Includes non-billed programs such as community health education, screenings, support groups, clinics, support services and community benefit operations.

## **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 health care and other community services to address unmet community health needs. The assessment incorporated components of primary data collection and secondary data analysis that focus 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 determinates of health, health care access, maternal and infant health, leading causes of death, disability and 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.

Targeted interviews were used 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. Interviewees included individuals who are 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. Input was obtained from the El Dorado County Public Health.

### **Priority Health Needs**

Health needs were identified from secondary data using the size of the problem (relative portion of population afflicted by the problem) and the seriousness of the problem (impact at individual, family, and community levels). The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets to address needs and discover gaps in resources.

The identified significant health needs were prioritized with input from the community. Interviewees were asked to rank the order of the health needs according to highest level of importance in the community. The total score for each significant health need (possible score of 4) was divided by the total number of responses for which data were provided, resulting in an overall average for each health need.

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 health care
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>.

## **Community Benefit Plan FY2020 – FY2022**

As a result of the 2019 CHNA, Marshall selected significant health needs it will address through its Implementation Strategy or Community Benefit Plan. The plan outlines the health needs the hospital will and will not address and the strategies it will use to address the selected health needs.

### **Significant Needs the Hospital Intends to Address**

Marshall intends to take actions to address the following health needs identified in the FY2019 CHNA:

- 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 #1:***

***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 #2 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 #1 - 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 #2 – 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 #1 – 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 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 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 be 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 #2 - 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 has elected 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 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, 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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