2026 Community Health Implementation Strategy and Plan

Adopted May 2026



Mark Twain Medical Center

San Andreas, California

Dignity Health.
Mark Twain Medical Center

Table of Contents

At-a-Glance Summary **3**

Our Hospital and the Community Served **4**
- About the Hospital 4
- Our Mission 4
- Financial Assistance for Medically Necessary Care 4
- Description of the Community Served 5

Community Assessment and Significant Needs **7**
- Significant Health Needs 7
  - Significant Needs the Hospital Does Not Intend to Address 8

2026 Implementation Strategy and Plan **9**
- Creating the Implementation Strategy 9
- Community Health Core Strategies 10
- Vital Conditions and the Well-Being Portfolio 11
- Strategies and Program Activities by Health Need 12

At-a-Glance Summary

Community Served	Mark Twain Medical Center (MTMC) is in San Andreas, CA and primarily serves the residents of Calaveras County. The population of the MTMC service area is 45,893.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs the hospitals intends to address with strategies and programs are: • Access to health care (primary and specialty care) • Behavioral health (mental health and substance use)
Strategies and Programs to Address Needs	The hospital intends to take several actions and dedicate resources to these needs, including: *Access to health care* Community Health Improvement Grants Program Financial assistance Flu vaccines Preventive screenings Rural Health Clinics *Behavioral health (mental health and substance use)* Behavioral health treatment and resource partnerships Community Health Improvement Grants Program Psychiatric telehealth Substance Abuse Counseling Support Services

Planned resources and collaborators to help address these needs, as well as anticipated impacts of the strategies and programs, are described in the "Strategies and Program Activities by Health Need" section of the document.

This document is publicly available online on the hospital's website. Written comments on this strategy and plan can be submitted to Mark Twain Medical Center, Philanthropy Department, 768 Mountain Ranch Road, San Andreas, CA 95249. To send comments or questions about this report, please contact Charanjit Singh at charanjit.singh@commonspirit.org.

Our Hospital and the Community Served

About the Hospital

Mark Twain Medical Center (MTMC) is a part of CommonSpirit Health, one of the largest nonprofit health systems in the U.S., with more than 2,200 care sites in 24 states coast to coast, serving patients in big cities and small towns across America.

- Located at 768 Mountain Ranch Road, San Andreas, CA 95249, MTMC is a 25-bed critical access hospital.
- Founded in 1951, MTMC provides inpatient acute care, outpatient services and emergency services. The Medical Staff provides a broad range of specialties that ensure access to high quality medical care in a rural community.
- In addition to being a major provider of health services, MTMC is also one of the area's largest employers. More than 300 people are employed at the hospital, Specialty Care Centers, and four Family Medical Centers.

Our Mission

The hospital's dedication to assessing significant community health needs and helping to address them in conjunction with the community is in keeping with its mission. As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Financial Assistance for Medically Necessary Care

It is the policy of CommonSpirit Health to provide, without discrimination, emergency medical care and medically necessary care in CommonSpirit hospital facilities to all patients, without regard to a patient's financial ability to pay.

This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain language summary and related materials are available in multiple languages on the hospital's website.

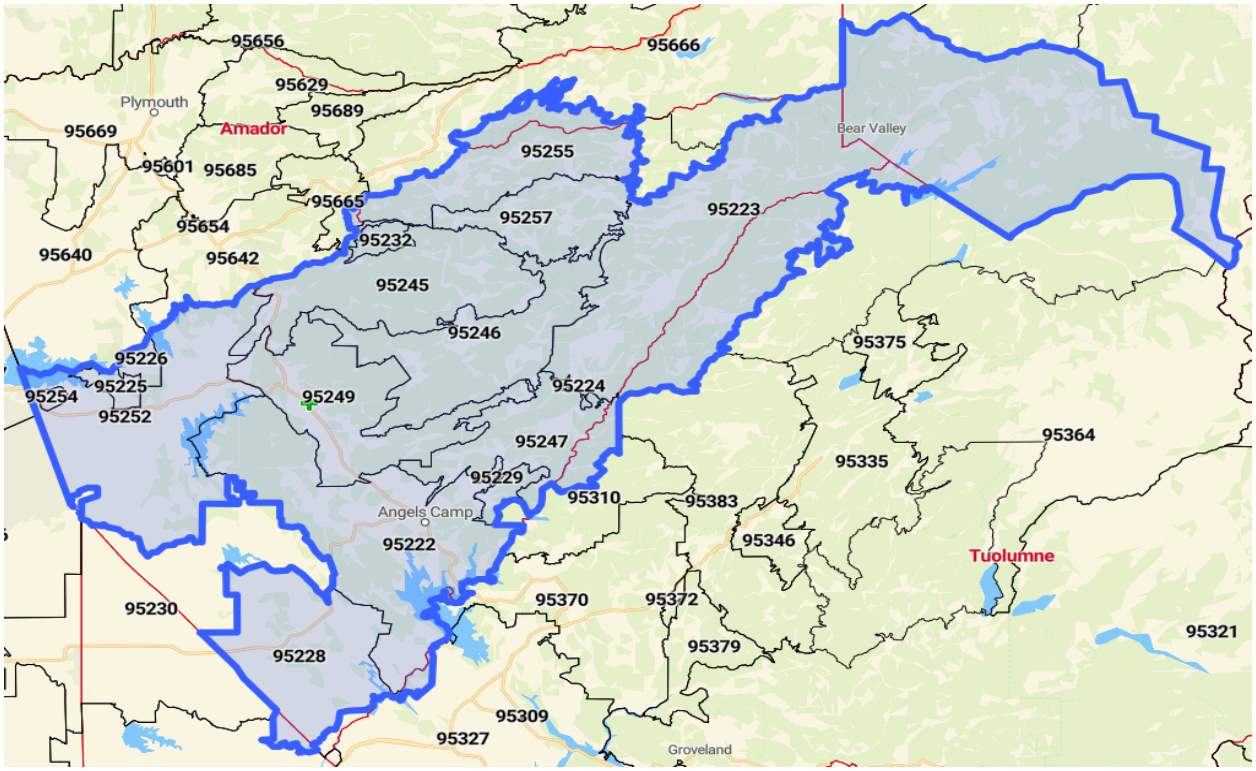


Description of the Community Served

The hospital service area includes the following cities and ZIP Codes.

Geographic Area	ZIP Codes
Altaville	95221
Angels Camp	95222
Arnold	95223
Avery	95224
Burson	95225
Campo Seco	95226 (zero population recorded)
Copperopolis	95228
Glencoe	95232
Hathaway Pines	95233
Mokelumne Hill	95245
Mountain Ranch	95246
Murphys and Douglas Flat	95247 (encompasses 95229)
Rail Road Flat	95248
San Andreas	95249
Vallecito	95251
Valley Springs	95252
Wallace	95254
West Point	95255
Wilseyville	95257

Map of the MTMC Service Area



A summary description of the community is provided below, and additional details can be found in the CHNA report online.

The population of the service area is 45,893. Children and youth, ages 0-17, make up 6.9% of the population, 54.3% are adults, ages 18-64, and 28.8% of the population are seniors, ages 65 and older. The largest portion of the population in the service area are non-Hispanic White residents (77.4%), 14% are Hispanic or Latino residents, 4.2% are non-Hispanic multiracial (two-or-more races) residents, 2.3% are Asian residents, 1.1% are Black or African American residents, 0.9% are American Indian or Alaskan Native residents, and 0.1% are Native Hawaiian or Pacific Islander residents. Those who identify with a race and ethnicity not listed represent 0.01% of the population.

Among the residents in the service area, 13.4% are at or below 100% of the federal poverty level (FPL) and 27.6% are at 200% of FPL or below. In the service area, 17.4% of children live in poverty, 11.8% of senior adults live in poverty, and 28.5% of families with female head of household with minor children live in poverty. The unemployment rate in the service area among the civilian labor force, averaged over 5 years, is 5.9%. The median household income in the service area is $81,425.

In the hospital service area, 6.7% of adults, ages 25 and older, lack a high school diploma, which is lower than the state rate (15.4%). 22.2% of area adults have a bachelor's or higher degree.

In the service area, 94.8% of the civilian, non-institutionalized population have health insurance, and 96.2% of children, ages 18 and younger, have health insurance coverage. Among county residents, 14.4% have Medi-Cal coverage.

The U.S. Health Services Administration (HRSA) designates medically underserved areas/populations (MUA) as areas or populations having too few primary care providers, high infant mortality, high poverty, or a high elderly population. Calaveras County does not have any areas designated as Medically Underserved Areas (MUAs) for primary care.

There are three categories of Health Professions Shortage Area (HPSA) designations based on the health discipline that is experiencing a shortage: 1) primary medical, 2) dental, and 3) mental health. The primary factor used to determine a HPSA designation is the number of health professionals relative to the population with consideration of high need. For primary care, the entirety of Calaveras County is designated as a Geographic HPSA, and for mental health the county is designated as a high-needs Geographic HPSA

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in May 2026. The CHNA report includes:

- description of the community assessed consistent with the hospital's service area;
- description of the assessment process and methods;
- data, information and findings, including significant community health needs;
- community resources potentially available to help address identified needs; and
- impacts of actions taken by the hospital since the preceding CHNA.

Additional details about the needs assessment can be found in the CHNA report, which is publicly available on the hospital's website or upon request from the hospital, using the contact information in the At-a-Glance Summary.

Significant Health Needs

The CHNA identified the significant needs in the table below, which also indicates which needs the hospital intends to address. Identified needs may include specific health conditions, behaviors or health care services, and also health-related social and community needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to care	Access to health care refers to the availability of primary care, specialty care, vision care and dental care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues.	•
Chronic diseases	A chronic disease or condition usually lasts for three months or longer and may get worse over time. Chronic diseases can usually be controlled but not always cured. The most common types of chronic diseases are cancer, heart disease, stroke, diabetes, and arthritis.	
Economic Insecurity	Economic insecurity is correlated with poor health outcomes. People with low incomes are more likely to have difficulty accessing health care, have poor-quality health care, and seek health care less often.	

Significant Health Need	Description	Intend to Address?
Food insecurity	The USDA defines food insecurity as limited or uncertain availability of nutritionally adequate foods or an uncertain ability to acquire foods in socially acceptable ways.	
Housing and homelessness	Homelessness is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing.	
Mental health[1]	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	●
Overweight and obesity, healthy eating and physical activity	Overweight and obesity are common conditions that are defined as the increase in size and amount of fat cells in the body. Obesity is a chronic health condition that raises the risk for chronic diseases. Overweight and obesity are linked to a lack of physical activity and unhealthy eating habits.	
Preventive practices	Preventive practices refer to health maintenance activities that help to prevent disease. For example, preventive care includes vaccines, routine health screenings (mammogram, colonoscopy, Pap smear) and injury prevention strategies.	
Substance use[1]	Substance use is the use of tobacco products, illegal drugs, prescription drugs, over-the-counter drugs or alcohol. Excessive use of these substances or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm.	●

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, MTMC will not directly address chronic disease, economic insecurity, food insecurity, housing and homelessness, overweight and obesity, and preventive practices as priority health needs. Knowing that there are not sufficient resources to address all the community health needs, MTMC chose to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are being addressed by others in the community.

[1] Mental health and substance use will be addressed within the scope of the behavioral health need.

2026 Implementation Strategy and Plan

This section presents strategies and program activities the hospital intends to deliver, fund or collaborate with others to address significant community health needs over the next three years, including resources for and anticipated impacts of these activities.

Planned activities are consistent with current significant needs and the hospital's mission and capabilities. The hospital may amend the plan as circumstances warrant, such as changes in community needs or resources to address them.



Creating the Implementation Strategy

The hospital is dedicated to improving community health and delivering community benefit with the engagement of its staff, clinicians and board, and in collaboration with community partners.

MTMC engaged hospital leaders in Marketing, Communications and Philanthropy and Executive Leadership to create the Implementation Strategy. The CHNA served as the resource document for a review of the significant health needs as it provided information on the severity of issues and included community input on the significant health needs. Also, the community prioritization of the significant health needs was taken into consideration. The programs and initiatives described here were selected on the basis of:

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

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally identified needs.

- Core Strategy 1: Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Core Strategy 2: Implement and sustain evidence-informed health improvement strategies and programs.
- Core Strategy 3: Strengthen community capacity to achieve equitable health and well-being.

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[2] to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

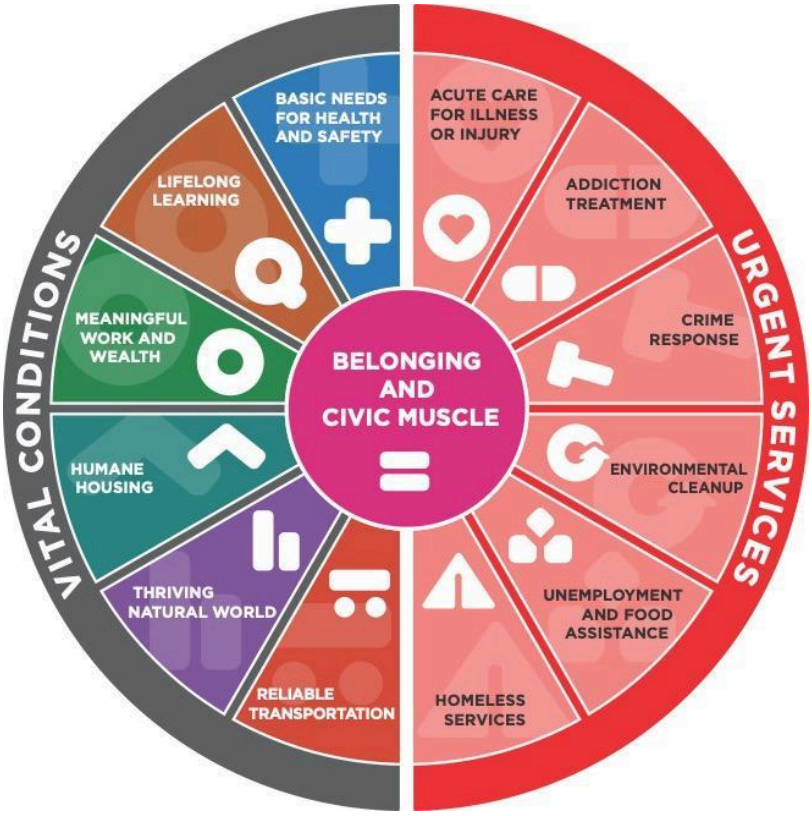
One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a well-being portfolio.

What are Vital Conditions?
These are characteristics of places and institutions that all people need all the time to be healthy and well. The vital conditions are related to social determinants or drivers of health, and they are inclusive of health care, multi-sector partnerships and the conditions of communities. They help create a community environment that supports health.

What are Urgent Services?
These are services that anyone under adversity may need temporarily to regain or restore health and well-being. Urgent services address the immediate needs of individuals and communities, say, during illness.

What is Belonging and Civic Muscle?
This is a sense of belonging and power to help shape the world. Belonging is feeling part of a community and valued for what you bring. Civic muscle is the power of people in a society to work across differences for a thriving future.

Well-Being Portfolio in this Strategy and Plan
The hospital's planned strategies and program activities that follow are each identified as aligning with one of the vital conditions or urgent services in this figure.



This helps to identify the range of approaches taken to address community needs and also acknowledges that the hospital is one community resource and stakeholder among many that are dedicated to and equipped for helping to address these needs and improve health.

[2] The Vital Conditions Framework and the Well-Being Portfolio were created by the Rippel Foundation and are being used with permission. Visit https://rippel.org/vital-conditions/ to learn more.

Strategies and Program Activities by Health Need

Health Need:	**Access to Health Care**				
Population(s) of Focus:	Individuals who experience barriers to accessing health care and preventive care services. Uninsured and underinsured people.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Grants Program	Award grant funds to nonprofit organizations to increase access to health care and preventive care.	●	●	●	US
Financial Assistance Program	Provide financial assistance to uninsured and underinsured patients.	●	●		US
Flu Vaccines	Distribute flu shots in partnership with the Public Health Department.	●	●		US
Rural health clinics	Expand primary and specialty care services in rural health clinics.	●	●	●	US
Screenings	Provide free lipid panel screening to identify persons with high cholesterol levels.	●	●		US
Planned Resources:	The hospital will provide health care providers, enrollment counselors, philanthropic cash grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include Calaveras County Public Health Department, Rural Health Clinics, and community-based organizations.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase access to health care for the medically underserved and reduce barriers to care.	Reduce to 5.9% the proportion of people who can't get medical care when they need it.	Healthy People 2030
Increase the number of adults who get recommended preventive health care.	11.5% of adults receive recommended preventive care services.	Healthy People 2030

Health Need:	**Behavioral Health (Mental Health and Substance Use)**				
Population(s) of Focus:	Individuals and families at-risk for and/or experiencing mental health and substance use distress. Residents facing barriers to accessing mental health care and substance use services.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Community Grants Program	Award grant funds to nonprofit organizations to increase access to health care and preventive care.	●	●	●	US
Community health education and resources	Address a variety of behavioral health care topics and provide local resources.	●	●		US
Psychiatric telehealth	Utilize telehealth for psychiatric assessments and provide medication prescriptions and recommendations for treatment.	●	●		US
Substance use counseling support services	Partner with Public Health to refer patients in need of substance use support services.	●	●		US
Planned Resources:	The hospital will provide mental health care providers, health educators, social workers, outreach communications, and program management support for these initiatives.				
Planned Collaborators:	Key partners include behavioral health providers, Calaveras County Public Health Department, schools and school districts, community-based organizations, Professional Mental Health Countywide task force.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase prevention, screening, assessment, and treatment of mental health disorders.	65.6% of adults, ages 18 and older with depression,	Healthy People 2030

	receive treatment.	
Reduce drug and alcohol addiction.	14% of people, ages 12 and older, receive substance use treatment when needed.	Healthy People 2030