Sequoia Hospital

Community Benefit 2024 Report and 2025 Plan

Adopted November 2024

Dignity Health®
Sequoia Hospital

A message from

Bill Graham, President, and Jan Barker, Chair of the Dignity Health Sequoia Hospital Community Board.

Dignity Health's approach to community health improvement aims to address significant health needs identified in the Community Health Needs Assessments that we conduct with community input, including from the local public health department. Our initiatives to deliver community benefit include financial assistance for those unable to afford medically necessary care, a range of prevention and health improvement programs conducted by the hospital and with community partners, and investing in efforts that address social drivers of health.

Sequoia Hospital shares a commitment with others to improve the health of our community and promote health equity, and delivers programs and services to help achieve that goal. The Community Benefit 2024 Report and 2025 Plan describes much of this work. This report meets requirements in California (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. We are proud of the outstanding programs, services and other community benefits our hospital delivers, and are pleased to report to our community.

In fiscal year 2024 (FY24), Sequoia Hospital provided $31,708,443 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services and other community benefits. The hospital also incurred $58,463,491 in unreimbursed costs of caring for patients covered by Medicare fee-for-service.

The hospital's Community Board reviewed, approved and adopted the Community Benefit 2024 Report and 2025 Plan at its November 6, 2024 meeting.

Thank you for taking the time to review our report and plan. We welcome any questions or ideas for collaborating that you may have, by reaching out to Marie.Violet@CommonSpirit.org or Tricia.Coffey@CommonSpirit.org.

Bill Graham
President

Jan Barker
Chairperson, Board of Directors

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At-a-Glance Summary

Hospital HCAI ID: 106410891
Report Period Start Date: July 1, 2023
Report Period End Date: June 30, 2024
This document is publicly available online at:
https://www.dignityhealth.org/bayarea/locations/sequoia/about-us/community-benefits

Community Served	Dignity Health Sequoia Hospital serves the cities in mid-county, south county, and the coastside of San Mateo County on the San Francisco Peninsula. The hospital service area includes the cities of Atherton, Belmont, Burlingame, Half Moon Bay, La Honda, Los Altos, Menlo Park, Mountain View, East Palo Alto/Palo Alto, Portola Valley, Redwood City, San Carlos and San Mateo with a total population of 609,356. While the population of the community served by Sequoia Hospital tends to be wealthier and better educated when compared to the state, there are a number of cities in the service area that experience high rates of poverty and health care disparities.
Economic Value of Community Benefit	$31,708,443 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits $58,463,491 in unreimbursed costs of caring for patients covered by Medicare fee-for-service. The hospital's net community benefit expenses for services to vulnerable populations and to the broader community are listed by category in the Economic Value of Community Benefit section of this report.
Significant Community Health Needs Being Addressed	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the hospital's most recent Community Health Needs Assessment (CHNA). Needs being addressed by strategies and programs are: ☑ Access to health care ☑ Healthy lifestyles (Chronic Diseases & Preventive Practices) ☑ Housing and homelessness ☑ Mental health
FY24 Programs and Services	The hospital delivered several programs and services to help address identified significant community health needs. These included: ● **Addressing Disparities in Health Care and the Digital Divide:** a digital literacy initiative for older adults that aims to enhance their health and well-being outcomes.

- **Art Faro Food Grant Program:** In partnership with the Sequoia Healthcare District, Sequoia Hospital provided funding for vulnerable populations on the Peninsula facing ongoing food insecurity.
- **Charitable cash and in-kind donations:** Provides cash and in-kind donations to community-based organizations to address access to health care.
- **Community Health Improvement Grants program**: Offers grants to nonprofit community organizations that provide access to health care programs and services.
- **Community Blood Pressure Screening:** Free blood pressure screenings for older adults provided by an RN at community centers. The program includes monitoring screening results, one-on-one counseling & chronic disease self-management and referrals to physicians for abnormal results.
- **Community Space Sharing Program:** This program offers meeting room space to nonprofit organizations addressing chronic diseases and preventive practices.
- **Diabetes Education Empowerment Program (D.E.E.P.):** Evidence based educational program designed to engage community residents in self-management practices for prevention and control of diabetes.
- **Discharge Planning for Homeless Patients:** Supportive services include a meal, weather-appropriate clothing, medications, transportation, infectious disease screening, vaccinations, and screening for affordable healthcare coverage. The San Mateo County Coordinated Entry System is contacted for shelter placement.
- **Financial assistance for the uninsured or underinsured**: Provides financial assistance (including discounts and charity care) to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.
- **Health Professions Education Program**: The hospital partners with educational or training programs to offer a clinical setting for training and educating nursing students and other allied health professionals.
- **Matter of Balance:** An evidence-based program designed to reduce the fear of falling and increase activity levels among older adults.
- **New Parents Support Group:** This group helps individuals navigate the challenges of parenting through structured, inclusive, strength-based, and empowering experiences.
- **Operation Access**: Sequoia Hospital partners with Operation Access to link donated surgical preventive care to uninsured and underinsured patients in San Mateo County at no charge to patients.
- **San Mateo County Navigation Center (Dental)** - Sequoia Hospital, in partnership with the Sequoia Healthcare District, granted funds to support a program at the San Mateo County Navigation Center, enabling dental students, residents, and interns to provide oral healthcare to formerly and currently homeless individuals.
- **Sequoia Health Equity Partnership:** In collaboration with Samaritan House, the Sequoia Hospital Foundation funds a diabetes nurse educator at their Redwood City clinic to assist at-risk patients with lifestyle modifications for successful diabetes management.

	• **Workforce Development Program**: In partnership with Wender Weis Foundation for Children, the program aims to introduce local high school students to entry level jobs in health care fields.
FY25 Planned Programs and Services 	For FY25, we will continue all FY24 programs and services. We will also incorporate findings from the 2025 Community Health Needs Assessment (CHNA). This will help us prioritize and allocate resources more effectively. Our planning will be updated based on the latest CHNA results.

Written comments on this report can be submitted to Sequoia Hospital Health & Wellness Department, 170 Alameda de las Pulgas, Redwood City, CA 94062. To send comments or questions about this report, please visit dignityhealth.org/sequoia/contact-us and select the “CHNA comments” in the drop-down.

Our Hospital and the Community Served

About Sequoia Hospital

Sequoia Hospital, located at 170 Alameda de la Pulgas, Redwood City, CA, is a member of Dignity Health, which is a part of CommonSpirit Health. Sequoia's Heart and Vascular Institute is a nationally known pioneer in advanced cardiac care. Sequoia has received national recognition as one of America's top 100 hospitals for cardiac care, as well as for superior patient safety from Healthgrades. Our Birth Center is consistently ranked as a favorite among Peninsula families, and we're also known for our Center for Total Joint Replacement and comprehensive emergency care. Our new state-of-the-art Pavilion combines the most advanced medical and surgical services with a unique healing environment, including private, spacious rooms and inviting garden areas. High technology meets Hello humankindness at Sequoia Hospital.

Our 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.

Our Vision

A healthier future for all – inspired by faith, driven by innovation, and powered by our humanity.

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

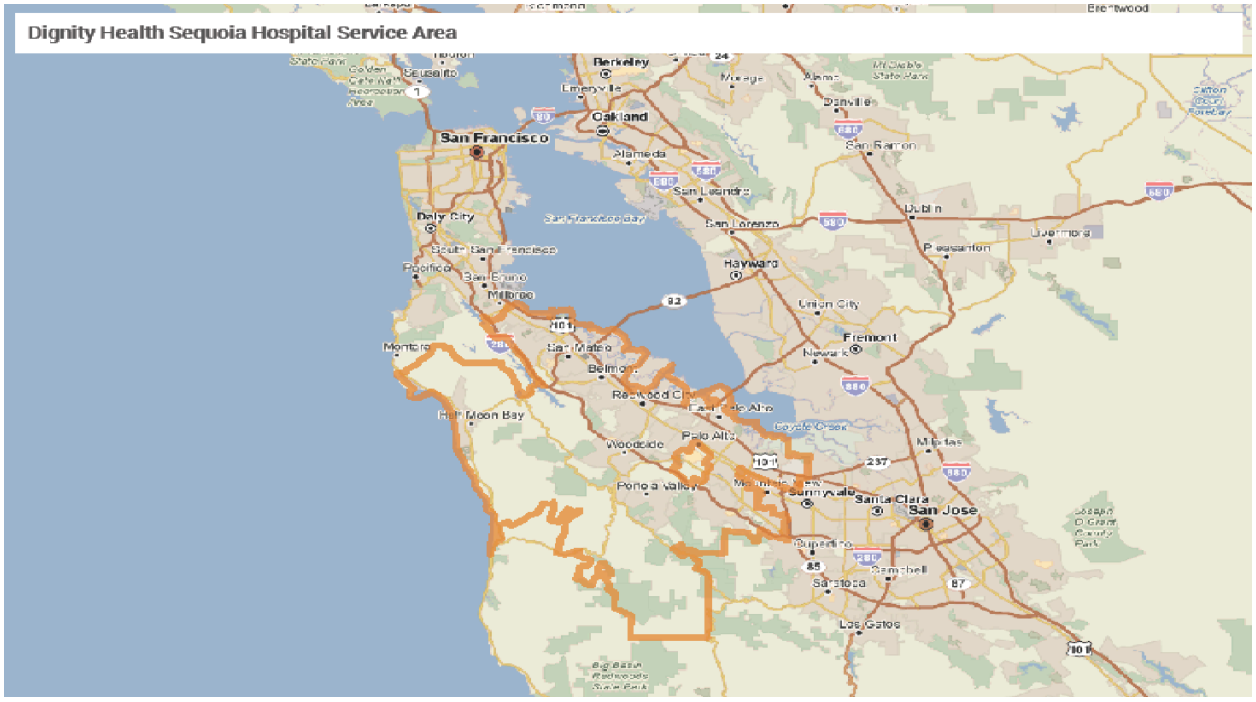
Sequoia Hospital serves 23 ZIP Codes in 13 cities in San Mateo County. A summary description of the community is below. Additional details can be found in the CHNA report online.

The population of the Sequoia Hospital service area is 609,356. Children and youth, ages 0-17, are 22.8% of the population, 61.4% are adults, ages 18-64, and 15.8% of the population are seniors, ages 65 and older. The largest portion of the population in the service area identifies as White/Caucasian (49.2%),

with 22.4% of the population identifying as Asian and 20.5% as Hispanic/Latino. 4.3% of the population identifies as multiracial (two-or-more races), 2.1% as Black/African American, 1% as Native Hawaiian/Pacific Islander, and 0.2% as American Indian/Alaskan Native.

Among the residents in the service area, 6.5% are at or below 100% of the federal poverty level (FPL) and 15.3% are at 200% of FPL or below. Educational attainment is a key driver of health. In the hospital service area, 8.3% of adults, ages 25 and older, lack a high school diploma, which is lower than the county (10.4%) and state (16.7%) rates. 63.1% of area adults have a Bachelor's degree or higher degree.

San Mateo County is designated a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA) for primary care, dental health and mental health.



Community Assessment and Significant Needs

The hospital engages in multiple activities to conduct its community health improvement planning process. These include, but are not limited, to conducting a Community Health Needs Assessment with community input at least every three years, identifying collaborating community stakeholder organizations, describing anticipated impacts of program activities and measuring program indicators.

Community Health Needs Assessment

The health issues that form the basis of the hospital's community benefit plan and programs were identified in the most recent CHNA report, which was adopted in May 2022. The hospital makes the

CHNA report widely available to the public online at https://www.dignityhealth.org/bayarea/locations/sequoia/about-us/community-benefits and upon request at the hospital's Community Health office.

The CHNA contains several key elements, including:
- Description of the assessed community served by the hospital;
- Description of assessment processes and methods;
- Presentation of data, information and findings, including significant community health needs;
- Community resources potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

Community Groups that Attended or Engaged in the CHNA:
- Bay Area Community Health Advisory Council (BACHAC)
- CA School Boards Association, Region 5
- Center for Independence of Individuals with Disabilities San Mateo
- Footsteps Child Care, Inc.
- HIP Housing
- LifeMoves
- Mental Health Association of San Mateo County
- One Life Counseling Services
- Peninsula Family Service
- Redwood City
- Redwood City School District Board
- Redwood City Together
- San Mateo County
- San Mateo County Health
- San Mateo County Human Trafficking Initiative
- San Mateo County Pride Center
- Samaritan House
- Second Harvest of Silicon Valley
- Sequoia Healthcare District
- Sonrisas Dental Health, Inc.
- Villages of San Mateo County

Vulnerable Populations Represented by These Groups:
- Racial and ethnic groups experiencing disparate health outcomes
- Socially disadvantaged groups, including the following:
    - The unhoused
    - People with disabilities
    - People identifying as lesbian, gay, bisexual, transgender, or queer
    - Individuals with limited English proficiency

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 and health care services, and also health-related social needs that have an impact on health and well-being.

Significant Health Need	Description	Intend to Address?
Access to health care	Access to health care refers to the availability of primary care, specialty care and dental care services. Health insurance coverage is considered a key component to ensure access to health care.	X
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.	X
COVID-19	Coronavirus disease (COVID-19) is an infectious disease caused by the SARS-CoV-2 virus.	
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.	X
Mental health	Mental health includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	X
Overweight and obesity	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 heart disease and is linked to many other health problems, including type 2 diabetes and cancer.	
Preventive practices	Preventive practices refer to health maintenance activities that help to prevent disease. For example, vaccines, routine health screenings (mammogram, colonoscopy, Pap smear) and injury prevention are preventive practices.	X

Significant Health Need	Description	Intend to Address?
Substance use	Substance use is the use of tobacco products, illegal drugs, prescription or 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.	
Tuberculosis	Tuberculosis (TB) is a contagious bacterial infection that usually attacks the lungs.	

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, Sequoia Hospital will not directly address COVID-19, food insecurity, overweight and obesity, substance use and tuberculosis as priority health needs. Knowing that there are not sufficient resources to address all the community health needs, Sequoia Hospital 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 currently addressed by others in the community.

2024 Report and 2025 Plan

This section presents strategies and program activities the hospital is delivering, funding or on which it is collaborating with others to address significant community health needs. It summarizes actions taken in FY24 and planned activities for FY25, with statements on impacts and community collaboration. Program Highlights provide additional detail on select programs.

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 Community Benefit Plan

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

Hospital and health systems participants included the hospital Leadership Team, Care Coordination,

Mission Integration, Health & Wellness, and the Community Advisory Committee.

Community input or contributions to this community benefit plan included contributions from 141 community members who completed a survey to provide insights on health needs, barriers to care, and available resources to address these needs. Additionally, 21 key informant interviews were conducted to gather further perspectives.

The programs and initiatives described here were selected on the basis of existing programs with evidence of success/impact, access to appropriate resources, ability to measure impact, and goal to address an immediate need; goal to address prevention and social determinants.

Community Health Core Strategies

Driven by a commitment to equity and social justice, we envision a future where health and well-being are attainable by all regardless of background or circumstance.

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources and engagement of participants both inside and outside of the health care delivery system.

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.

- Extend the care continuum by aligning and integrating clinical and community-based interventions.
- Strengthen community capacity to achieve equitable health and well-being.
- Implement and sustain evidence-based health improvement program initiatives.

Report and Plan by Health Need

The tables below present strategies and program activities the hospital has delivered or intends to deliver to help address significant health needs identified in the community health needs assessment.

They are organized by health need and include statements of strategy and program impact, and any collaboration with other organizations in our community.

Health Need: Access to Health Care

Strategy or Program	Summary Description	Active FY24	Planned FY25
Financial assistance for the uninsured or underinsured	Sequoia Hospital provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	☑	☑
Health Professions Education Program	The hospital partners with educational or training programs to offer a clinical setting for training and educating nursing students and other allied health professionals.	☑	☑
Community Blood Pressure Screenings	Free blood pressure screenings for older adults provided by an RN at community centers. The program includes monitoring screening results, one-on-one counseling & chronic disease self-management and referrals to physicians for abnormal results.	☑	☑
Workforce Development Program	In partnership with Wender Weis Foundation for Children, the program aims to introduce local high school students to entry level jobs in health care fields.	☑	☑
Operation Access Partnership	Sequoia Hospital partners with Operation Access to link donated surgical preventive care to uninsured and underinsured patients in San Mateo County at no charge to patients.	☑	☑
Addressing Disparities in Health Care and the Digital Divide	Sequoia Hospital helps support and promote AnewVista Community Services programming, a digital literacy initiative for older adults that aims to enhance their health and well-being outcomes.	☑	☑
San Mateo County Navigation Center (Dental)	Sequoia Hospital, in partnership with the Sequoia Healthcare District, granted funds to support a program at the San Mateo County Navigation Center, enabling dental students, residents, and interns to provide oral healthcare to formerly and currently homeless individuals.	☑	☑
Community Health Improvement Grants program	Offers grants to nonprofit community organizations that provide access to health care programs and services.	☑	☑
Charitable cash and in-kind donations	Provides cash and in-kind donations to community-based organizations to address access to health care.	☑	☑

Goal and Impact: The hospital's initiatives to address access to care are anticipated to result in: increased access to health care for the medically underserved, reduced barriers to care, increased availability and access to preventive care services and increased local health care workforce.

Collaborators:

- AnewVista Community Services
- Bay Area Community Health Advisory Council (BACHAC)
- Casa Circulo Cultural
- County of San Mateo
- HealthPlan of San Mateo
- Mental Health Association of San Mateo County
- Operation Access
- Pathways Home Health and Hospice
- Paratransit Coordinating Council (PCC)
- Redwood City Together
- Samaritan House
- San Mateo County Health
- San Mateo County Office of Education
- San Mateo Pride Center
- Sequoia Healthcare District
- Sequoia Union High School District
- Sonrisas Dental Health, Inc.
- United Through Education: Familias Unidas
- University of the Pacific Arthur A. Dugoni School of Dentistry
- Villages of San Mateo
- Wender Weis Foundation for Children

Health Need: Healthy Lifestyles (Chronic Diseases & Preventive Practices)

Strategy or Program	Summary Description	Active FY24	Planned FY25
Art Faro Food Grant Program	In partnership with the Sequoia Healthcare District, Sequoia Hospital provided funding for vulnerable populations on the Peninsula facing ongoing food insecurity.	☑	☑
Community Blood Pressure Screenings	Free screenings for older adults provided by an RN at community centers. The program includes monitoring screening results, one-on-one counseling & chronic disease self-management and referrals to physicians for abnormal results.	☑	☑
Sequoia Health Equity Partnership	In partnership with Samaritan House, a leading non-profit serving San Mateo County, the Sequoia Hospital Foundation will provide the funding necessary to bring a diabetes nurse educator to their Redwood City clinic to work directly with at-risk patients to provide the necessary tools and education regarding critical lifestyle modifications	☑	☑

	(meal planning, activity/exercise and stress management) so they can live with diabetes successfully.		
Diabetes Empowerment Education Program (D.E.E.P.)	Evidence based educational program designed to engage community residents in self-management practices for prevention and control of diabetes.	☑	☑
Matter of Balance	An evidence-based program designed to reduce the fear of falling and increase activity levels among older adults.	☑	☑
Community Space Sharing Program	Provides meeting room overhead and space to the nonprofit organization Bay Area Community Health Advisory Council (BACHAC). BACHAC's mission is to increase awareness of major health issues affecting African Americans and diverse communities, advocate for increased health education and access to resources and actively encourage accountability for healthy lifestyles.	☑	☑
Community Health Improvement Grants program	Offers grants to nonprofit community organizations that provide healthy lifestyles (chronic diseases & preventive practices) programs and services.	☑	☑
Charitable cash and in-kind donations	Provides cash and in-kind donations to community-based organizations to address healthy lifestyles (chronic diseases & preventive practices).	☑	☑

Goal and Impact: The hospital's initiatives to improve healthy lifestyles are anticipated to result in: increased knowledge of healthy eating and physical activity, increased identification and treatment of chronic diseases, increased compliance with chronic disease prevention and management recommendations.

Collaborators:

- Bay Area Community Health Advisory Council (BACHAC)
- Ecumenical Hunger Program
- Fair Oaks Adult Activity Center
- Fall Prevention Coalition of San Mateo County
- Friends of the Veterans Memorial Senior Center
- Karat School Project
- LifeMoves
- Little House Activity Center
- Medical Equipment Loan Program: MELP
- Redwood City Parks, Recreation and Community Services
- Redwood City School District
- Samaritan House
- San Carlos Adult Community Center
- Sandpiper Community Center
- San Mateo County Breastfeeding Advisory Committee
- San Mateo County Human Trafficking Initiative
- The San Mateo County Paratransit Coordinating Council (PCC)
- San Mateo County Tobacco Prevention Program
- Sequoia Healthcare District
- Sequoia Union High School District
- Sonrisas Dental Health
- Twin Pines Senior & Community Center
- United through Education – Familias Unidas

- Upward Scholars
- Veterans Memorial Senior Center
- Villages of San Mateo County

Health Need: Housing and Homelessness

Strategy or Program	Summary Description	Active FY24	Planned FY25
Discharge planning for homeless patients	Supportive services are offered that include a meal, weather-appropriate clothing, medications, transportation, infectious disease screening, vaccinations and screening for affordable health care coverage. For shelter resources, the San Mateo County Coordinated Entry System is called for assistance. The hospital care coordinators and social workers engage the services of LifeMoves "Homeless Outreach Team" (HOT) to provide a broad range of services, which include outreach and engagement, intensive case management (including support in following-up on medical appointments), benefits enrollment, and transportation to and from medical appointments.	☑	☑
Community Health Improvement Grants program	Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.	☑	☑
Charitable cash and in-kind donations	Provides cash and in-kind donations to community-based organizations to address housing and homelessness.	☑	☑

Goal and Impact: The hospital's initiatives to address housing and homelessness are anticipated to result in: improved health care delivery to persons experiencing homelessness and increased access to community-based services for persons experiencing homelessness.

Collaborators:
- Fair Oaks Community Center
- HIP Housing
- LifeMoves
- Redwood City Police Department
- Samaritan House (SMC Coordinated Entry System)
- San Mateo County Behavioral Health & Recovery Services

Health Need: Mental Health

Strategy or Program	Summary Description	Active FY24	Planned FY25
New Parents support group	This group helps individuals navigate the challenges of parenting through structured, inclusive, strength-based, and empowering experiences.	☑	☑
Community Space Sharing Program	Provides meeting room overhead and space to the nonprofit organization OneLife Counseling Services for community members to feel connected and have a safe place to access mental health services.	☑	☑
Community Health Improvement Grants program	Offers grants to nonprofit community organizations that provide mental health programs and services.	☑	☑
Charitable cash and in-kind donations	Provides cash and in-kind donations to community-based organizations to address mental health issues.	☑	☑

Goal and Impact: The hospital's initiatives to address mental health are anticipated to result in: increased access to mental health services in the community, and improved screening and identification of mental health needs.

Collaborators:

- Acknowledge Alliance
- Community Overcoming Relationship Abuse (CORA)
- Friends For Youth
- LifeMoves
- Mental Health Association of San Mateo County
- One Life Counseling Services
- PAL Center
- Peninsula Kidpower Teenpower Fullpower
- Samaritan House
- Sequoia Union High School District
- Siena Youth Center

Community Health Improvement Grants Program

One important way the hospital helps to address community health needs is by awarding financial grants to non-profit organizations working together to improve health status and quality of life. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations related to CHNA priorities.

In FY24, the hospital awarded the grants below totaling $149,928. Some projects also may be described elsewhere in this report.

Grant Recipient	Project Name	Health Needs Addressed	Amount
Acknowledge Alliance	Collaborative Counseling Program	Mental health	$20,000
Community Overcoming Relationship Abuse - CORA	CORA Family Centered Mental Health Program	Mental health	$20,000
Friends For Youth	Friends For Youth	Mental health	$20,000
Kidpower Teenpower Fullpower	Peninsula Kidpower Teenpower Fullpower	Mental health	$22,500
LifeMoves	LifeMoves Homeless Outreach Team	Housing and homelessness	$22,428
United through Education-Familias Unidas	Familias Unidas Family Engagement Workshop	Healthy lifestyles (Chronic Diseases & Preventive Practices)	$22,500
Villages of San Mateo County	Villages of San Mateo County	Access to health care	$22,500

Program Highlights

The following pages describe a sampling of programs and initiatives listed above in additional detail, illustrating the work undertaken to help address significant community health needs.

Community Blood Pressure Screening

Significant Health Needs Addressed	☑ Access to health care ☑ Healthy lifestyles (Chronic Diseases & Preventive Practices) ☐ Housing and homelessness ☐ Mental health
Program Description	Health screening program conducted monthly at 6 sites in the community by a registered nurse. Services include free screenings for blood pressure, monitoring screening results, one-on-one counseling & chronic disease self-management education and referrals to physicians for abnormal results.
Population Served	Older Adults
Program Goal / Anticipated Impact	Early detection and lifestyle changes or surveillance, to reduce the risk of disease, or to detect it early enough to treat it most effectively.

FY 2024 Report	
Activities Summary	A hospital community health nurse offered complimentary blood pressure screenings at six community locations. These services encompassed screening result monitoring, personalized counseling & chronic disease self-management and facilitating referrals to physicians in cases of abnormal results.
Performance / Impact	Of the **687** blood pressure screenings provided: ● **1/3** participants receiving one-on-one counseling ● **61** referrals made to primary care physician ● **73%** of participants surveyed shared their results with their physician ● **1 in 5** participants surveyed said their physician made a change to their medications, diet and/or exercise plan based on screening results ● **100%** of participants surveyed rated the service as above average or excellent
Hospital's Contribution / Program Expense	.2 FTE
FY 2025 Plan	
Program Goal / Anticipated Impact	Building on the success of the FY24 blood pressure screening program, the goal for FY25 is to expand our outreach and further enhance the health outcomes of participants. Anticipated measurable outcomes include: ● Aim to provide at least 700 screenings, up from 687 in FY24. ● Target 250 participants receiving personalized counseling one-on-one counseling & chronic disease self-management, increasing engagement with health professionals. ● Set a goal of 70 referrals made to primary care physicians, ensuring that more participants receive necessary follow-up care. ● Strive for 75% of participants to share their screening results with their physicians, improving continuity of care and fostering proactive health management. ● Aim for 25% of participants surveyed to report changes to their medications, diet, or exercise plans based on screening results, reflecting the impact of early detection on health outcomes. ● Ensure that 100% of participants continue to rate the service as above average or excellent. ● Medication Wallet Card FY 2025: A health education pilot program at Fair Oaks Adult Activity Center focused on increasing the awareness around the importance of carrying and sharing updated medication wallet cards with their healthcare providers. A nurse and Spanish translator will assist program participants accurately complete their portable medication record.

Planned Activities	Our intention is to continue the activities from FY24 into FY25.

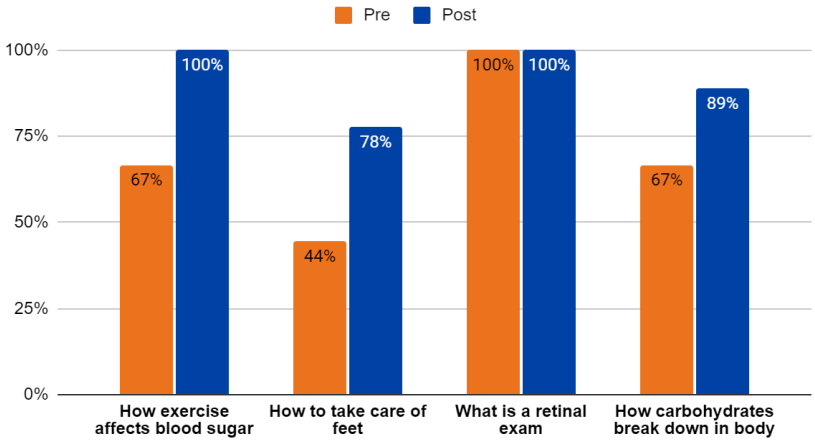
Diabetes Empowerment Education Program (D.E.E.P.)

Significant Health Needs Addressed	☐ Access to health care ☑ Healthy lifestyles (Chronic Diseases & Preventive Practices) ☐ Housing and homelessness ☐ Mental health
Program Description	Evidence based educational program designed to engage community residents in self-management practices for prevention and control of diabetes. The program consists of 6 two-hour sessions.
Population Served	Individuals who are pre-diabetic or diabetic
Program Goal / Anticipated Impact	The program aims to improve and maintain the quality of life for individuals who are pre-diabetic or diabetic by preventing complications and incapacities associated with the condition. A key focus is on increasing physical activity and developing self-care skills, empowering patients to manage their health more effectively. Additionally, the program seeks to enhance the relationships between patients and healthcare providers, fostering better communication and collaboration. By utilizing available resources, the program ensures that participants have access to the support they need for long-term health and well-being.

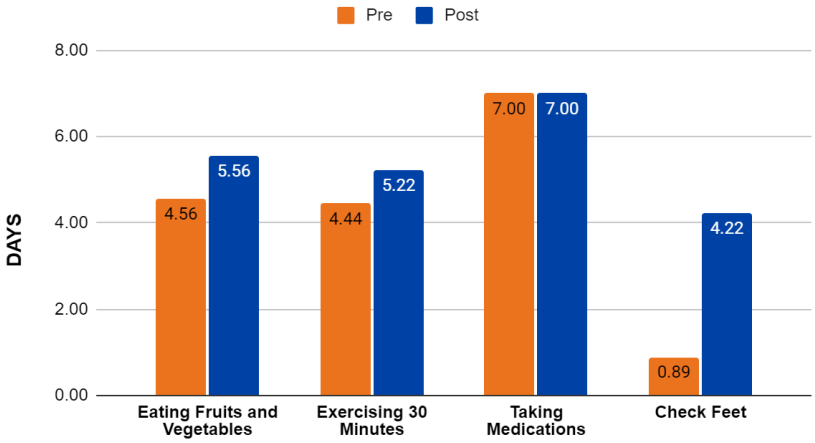
FY 2024 Report

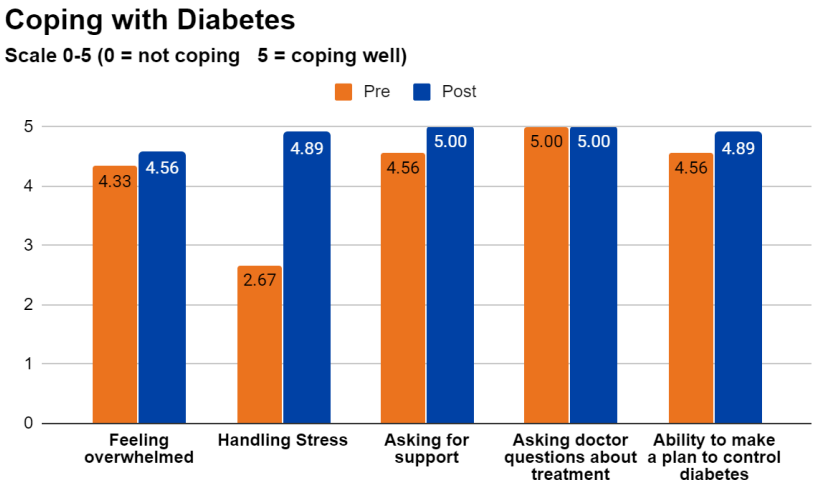
Activities Summary	We initially planned to offer two Diabetes Empowerment Education Program (D.E.E.P.) classes to the community. However, due to low enrollment, one session had to be canceled. In response, we refocused our marketing efforts, including community talks, to increase awareness and engagement. As a result, we successfully hosted a D.E.E.P. class at maximum capacity in the spring of 2024, providing valuable education and support to participants.
Performance / Impact	**Pre & Post Survey Results** Respondents: 9 Retention Rate: 100%

Diabetes Knowledge



Self-Care Measures





Hospital's Contribution / Program Expense	.2 FTE

FY 2025 Plan	
Program Goal / Anticipated Impact	The goal for FY25 is to successfully offer and complete two Diabetes Empowerment Education Program (D.E.E.P.) classes for the community. Building on lessons learned from previous enrollment challenges, we will strengthen our outreach and marketing strategies to increase participation.
Planned Activities	Our intention is to continue the activities from FY24 into FY25.

Matter of Balance (MOB)	
Significant Health Needs Addressed	☐ Access to health care ☑ Healthy lifestyles (Chronic Diseases & Preventive Practices) ☐ Housing and homelessness ☐ Mental health
Program Description	Matter of Balance (MOB) is an evidence based program that acknowledges the risk of falling but emphasizes practical coping skills to reduce this concern. Trained facilitators conduct eight two-hour sessions that include simple exercises to increase strength and balance.
Population Served	Older Adults
Program Goal / Anticipated Impact	Reduce the fear of falling and increase activity levels among older adults who manifest this concern.
FY 2024 Report	
Activities Summary	Delivered **MOB Refresher Training** for 2 coaches. Conducted two **MOB Peer Trainings**, training a total of 7 coaches. Facilitated 4 **Matter of Balance (MOB)** classes, reaching: ● **Sept 11 - Oct 4:** 8 participants ● **Feb 13 - April 2:** 13 participants ● **April 15 - April 29:** 11 participants ● **June 18 & June 25 (Stanford substitution):** 11 participants

Performance / Impact

Pre & Post Class Surveys		
I can find a way to reduce falls	**Pre**	**Post**
Very sure	19%	69%
Sure	38%	25%
Somewhat sure	44%	0%
Not at all sure	0%	0%
No answer	0%	6%

I can protect myself if I fall	**Pre**	**Post**
Very sure	19%	38%
Sure	31%	25%
Somewhat sure	31%	38%
Not at all sure	19%	0%
No answer	0%	0%

I can increase my physical strength	**Pre**	**Post**
Very sure	50%	81%
Sure	31%	6%
Somewhat sure	19%	13%
Not at all sure	0%	0%
No answer	0%	0%

I can become more steady on my feet	**Pre**	**Post**
Very sure	31%	75%
Sure	44%	19%
Somewhat sure	25%	6%
Not at all sure	0%	0%
No answer	0%	0%

Class Evaluations	
As a result of this class, I have made changes to my environment.	
Strongly agree	63%
Agree	31%
Disagree	0%
Strongly Disagree	0%
No answer	6%
As a result of this class, I feel more comfortable increasing my activity.	
Strongly agree	56%
Agree	44%
Disagree	0%
Strongly Disagree	0%
No answer	0%
As a result of this class, I plan to continue exercising.	
Strongly agree	81%
Agree	19%
Disagree	0%
Strongly Disagree	0%
No answer	0%
As a result of this class, I feel more comfortable talking with others about my fear of falling.	
Strongly agree	81%
Agree	19%
Disagree	0%
Strongly Disagree	0%
No answer	0%

Hospital's Contribution / Program Expense	.2 FTE
FY 2025 Plan	
Program Goal / Anticipated Impact	In FY25, the program will aim to enhance the quality and impact of fall prevention efforts by focusing on delivering two high-quality **Matter of Balance (MOB)** classes, targeting a total of **20 participants**. Additionally, the program will continue to provide ongoing **MOB Peer Training** and **Refresher Trainings** to maintain coach proficiency and expand outreach.
Planned Activities	Our intention is to continue the activities from FY24 into FY25.

Homeless Outreach Team (HOT) Program	
Significant Health Needs Addressed	☑ Access to health care ☑ Healthy lifestyles (Chronic Diseases & Preventive Practices) ☑ Housing and homelessness ☑ Mental health
Program Description	**2024 Community Health Improvements Grants Program** 12-month grant period: Jan. – Dec. 2024 **Lead Organization:** LifeMoves **Project Name:** Homeless Outreach Team (HOT) Program **Project Description:** The HOT works with unsheltered individuals in San Mateo County (SMC) with the goal of encouraging positive decision-making, reducing hospital and emergency room visits, and leaving homelessness.
Population Served	Unsheltered homeless individuals and families in San Mateo County.
Program Goal / Anticipated Impact	The HOT will assist unsheltered individuals to develop a strategy to move to stable housing.
FY 2024 Report	
Activities Summary	HOT staff worked with project partners to connect with unsheltered individuals in the community surrounding Sequoia Hospital, including individuals being discharged from hospitals into homelessness. HOT staff provided information on available medical, behavioral health, housing, and other services available in SMC. HOT staff responded to calls from project partners within 24 hours (excluding weekends) and reached out to identified clients in need. Depending on individual circumstances, the HOT coordinated with local partners to address immediate health and safety concerns. Eligible clients who wish to be connected to housing or shelter were entered into the San Mateo County's Coordinated Entry System (CES). HOT staff met clients to conduct an assessment for local emergency interim housing or other housing options. HOT staff connected interested, eligible clients to community partners and county agencies for supportive services as appropriate. After completing an intake assessment, HOT staff provided ongoing case management and support connections to critical community services.

Performance / Impact	**Mid-Year Report (January - June) due July 31, 2024** HOT staff provided 75 unsheltered individuals information on available medical, behavioral health, housing, and other services available in SMC. HOT staff responded to 13 calls from project partners within 24 hours (excluding weekends) and reached out to identified clients in need. 62 eligible clients, who wished to be connected to housing or shelter, were entered into San Mateo County's Coordinated Entry System (CES). HOT staff met the clients to conduct an assessment for local emergency interim housing or other housing options. HOT staff connected 19 eligible clients to community partners and county agencies for supportive services as appropriate. After completing an intake assessment, HOT staff provided ongoing case management and support connections to critical community services.
Hospital's Contribution / Program Expense	Dignity Health Sequoia Hospital Improvement Grants award amount: $22,428.
FY 2025 Plan	
Program Goal / Anticipated Impact	The HOT will assist unsheltered individuals to develop a strategy to move to stable housing.
Planned Activities	Continue all grant-funded activities through December 2024. Grantee to submit the Final Report to Sequoia Hospital Dignity Health by February 2025.

The Whole Health for Youth (WHY) Collaborative

Significant Health Needs Addressed	☑ Access to health care ☐ Healthy lifestyles (Chronic Diseases & Preventive Practices) ☐ Housing and homelessness ☑ Mental health
Program Description	**2024 Community Health Improvements Grants Program** 12-month grant period: Jan. – Dec. 2024 **Lead Organization:** Friends for Youth **Project Name:** Whole Health for Youth (WHY) Collaborative **Project Description:** a multi-agency partnership that aims to improve youth mental health and wellness through coordinated prevention and early intervention services. WHYwill achieve this by hosting

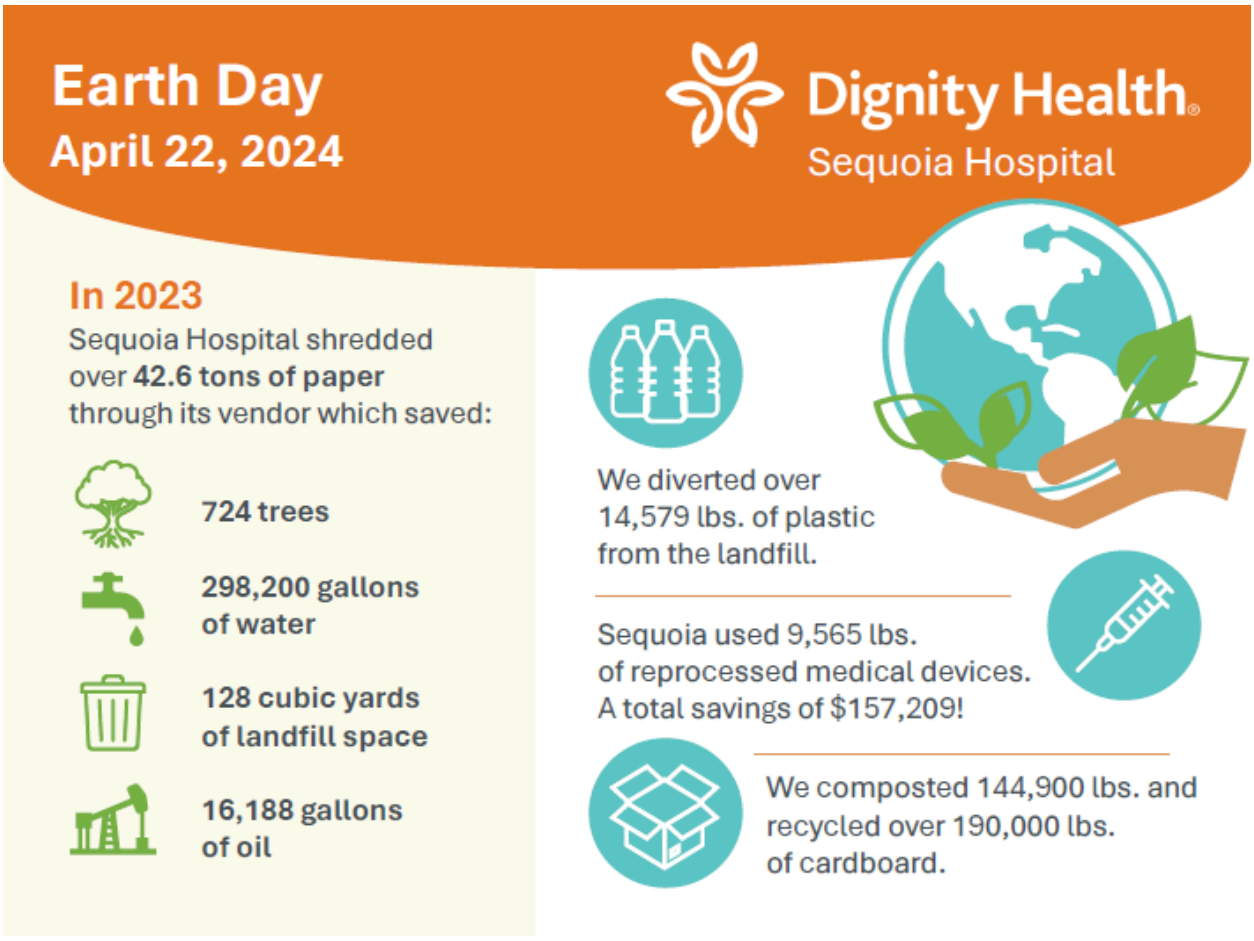
	site-based mentorship groups and peer counseling groups to youth between 6th and 10th grade.
Population Served	Youth ages 11-25, their parents/guardians, program staff, volunteers, and school staff. Families served are primarily Latinx, first-generation immigrants, Spanish-speaking, and from low-income households in Redwood City, North Fair Oaks, and other nearby areas.
Program Goal / Anticipated Impact	Improved quality of participants' social-emotional health and support networks, and decreased stigma around mental health.
FY 2024 Report	
Activities Summary	Friends for Youth offered group mentoring to students in 6th through 10th at the PAL Center and Siena Youth Center. Each mentoring group met once per week and included 8-12 students and 4-6 mentors. Curriculum focused on developing social-emotional skills. One Life Counseling led Peer Counseling Groups met on-site at Siena Youth Center and PAL Center. The groups lasted for 6 weeks and focused on skill-building relating to emotional self-regulation, self-care, and mental health related topics.
Performance / Impact	**Mid-Year Report (January - June) due July 31, 2024** Friends for Youth provided impactful group mentoring to 125 students in 6th through 10th grade at the PAL Center and Siena Youth Center. One Life Counseling facilitated Peer Counseling Groups for 36 students at Siena Youth Center and PAL Center.
Hospital's Contribution / Program Expense	Dignity Health Sequoia Hospital Improvement Grants award amount: $20,000
FY 2025 Plan	
Program Goal / Anticipated Impact	Improved quality of participants' social-emotional health and support networks, and decreased stigma around mental health.
Planned Activities	Continue all grant-funded activities through December 2024. Grantee to submit the Final Report to Sequoia Hospital Dignity Health by February 2025.

Other Programs and Non-Quantifiable Benefits

The hospital delivers community programs, services and non-quantifiable benefits in addition to those described elsewhere in this report. Like those programs and initiatives, the ones below are a reflection of the hospital's mission and its commitment to improving community health and well-being.

Sequoia Hospital Health Care Equity Workgroup - composed of representatives from various hospital departments, including but not limited to: Administration, Quality Improvement, Care Coordination, Health & Wellness, Human Resources, Mission Integration, Nursing Leadership, Patient Registration/Admitting, and Clinical Informatics. The workgroup functions to develop a Health Equity plan to address equity opportunities, and provide ongoing health equity performance evaluation.

Sequoia Environmental Action Committee (or "Green Team") - The team is responsible for establishing annual environmental performance goals, monitoring progress, and submitting quarterly and annual reports to the Safety and Clinical Effectiveness Committees. They oversee the implementation of the environmental policy, educate employees on environmental issues, and seek partnerships within the community to support ecological projects and advocacy initiatives. Below is a sample of Sequoia's Hospital accomplishments:



Economic Value of Community Benefit

The economic value of all community benefit is reported at cost. Patient financial assistance (charity care) reported here is as reported to the Department of Health Care Access and Information in Hospital Annual Financial Disclosure Reports, as required by Assembly Bill 204. The community benefit of Medicaid, other means-tested programs and Medicare is calculated using a cost-to-charge ratio to determine costs, minus revenue received for providing that care. Other net community benefit expenses are calculated using a cost accounting methodology. Restricted offsetting revenue for a given activity, where applicable, is subtracted from total expenses to determine net benefit in dollars.

Sequoia Hospital					
Complete Summary - Classified (Programs) Including Non Community Benefit (Medicare)					
For period from 07/01/2023 through 06/30/2024					
	Persons	**Expense**	**Offsetting Revenue**	**Net Benefit**	**% of Expenses**
Benefits for Poor					
Financial Assistance	**951**	**$3,687,820**	**$0**	**$3,687,820**	**1.1%**
Medicaid	**6,306**	**$34,511,824**	**$10,576,463**	**$23,935,361**	**7.1%**
Community Services					
A - Community Health Improvement Services	511	$17,749	$0	$17,749	**0.0%**
E - Cash and In-Kind Contributions	10	$867,055	$17,500	$849,555	**0.3%**
G - Community Benefit Operations		$2,121,089	$0	$2,121,089	**0.6%**
Totals for Community Services	**521**	**$3,005,893**	**$17,500**	**$2,988,393**	**0.9%**
Totals for Benefits for Poor	**7,778**	**$41,205,537**	**$10,593,963**	**$30,611,574**	**9.1%**
Benefits for Broader Community					
Community Services					
A - Community Health Improvement Services	1,579	$29,126	$0	$29,126	**0.0%**
B - Health Professions Education	89	$1,065,090	$0	$1,065,090	**0.3%**
F - Community Building Activities	136	$2,653	$0	$2,653	**0.0%**
Totals for Community Services	**1,804**	**$1,096,869**	**0**	**$1,096,869**	**0.3%**
Totals for Broader Community	**1,804**	**$1,096,869**	**$0**	**$1,096,869**	**0.3%**
Totals - Community Benefit	**9,582**	**$42,302,406**	**$10,593,963**	**$31,708,443**	**9.4%**
Medicare	**20,439**	**$143,635,467**	**$85,171,976**	**$58,463,491**	**17.4%**
Totals Including Medicare	**30,021**	**$185,937,873**	**$95,765,939**	**$90,171,934**	**26.9%**

*For the Medicaid provider fee program effective for the two-year period of January 1, 2023 - December 31, 2024, the State of California received Centers for Medicare & Medicaid Services approval in December 2023. As such, during the fiscal year July 1, 2023 - June 30, 2024, the hospital recognized provider fee net income of -$8,497,691 covering 18 months dating back to January 2023. Subtracting the six months of net provider fee attributable to the prior fiscal year, FY24 Medicaid net benefit would be $20,893,420 and total community benefit including Medicare would be $87,129,993.

Hospital Board and Committee Rosters

SEQUOIA HOSPITAL COMMUNITY BOARD

Chair
Jan Barker
Managing Director
MatchPoint Partners

Secretary
Mojdeh Talebian, MD
Pulmonolgist

President, Medical Staff
C. Dale Young, MD
Chief of Medical Staff
Sequoia Hospital

Members
Dorena Chan
Vice President and Assistant General Counsel
Oracle Corporation

Sandra Ferrando
Community Member

Bill Graham
President, Sequoia Hospital

Connie Guerrero
Senior Financial Controls Manager
Swinterton Builders

Sunil Pandya
Market Executive
Wells Fargo

(Amita) Niki Saxena, MD
Pediatrician

Lisa Tealer
Executive Director
Bay Area Community Health Advisory Council
(BACHAC)

Tykia Warden
Vice President, Institutional Relations
NAACP

SEQUOIA HOSPITAL COMMUNITY ADVISORY COMMITTEE (CAC)

Chair
Melissa Platte
Executive Director
Mental Health Association of San Mateo County

Members
Susan Eldredge
Executive Director
Villages of San Mateo County

Laura Fanucchi
Associate Executive Director
HIPhousing

Sandra Ferrando
Community Member
Sequoia Hospital Community Board Member

Ted Hannig
Attorney
Hannig Law Firm

Diane Howard
City of Redwood City Council Member

Karen F. Krueger
Executive Director of Philanthropy
Pathways Home Health & Hospice

Alisa Greene MacAvoy
RCSD Board of Trustee
Trustee At-Large

Lisa Tealer, (She/Her)
Sequoia Hospital Community Board Member
Executive Director
Bay Area Community Health Advisory Council (BACHAC)

Sequoia Hospital Staff
Bill Graham
Liaison to Sequoia Hospital Community Board
President

Lindsey Hincks
Chief Philanthropy Officer

Marie Violet
Director, Health & Wellness

Ki Do Ahn
Manager of Mission Integration

Tricia Coffey
Manager of Community Health Outreach