Sequoia Hospital

Community Benefit 2018 Report and 2019 Plan
A message from

William Graham, president and CEO of Sequoia Hospital, and Betty Till, 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 multi-pronged initiatives to improve community health 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 determinants of health.

Sequoia Hospital shares a commitment with others to improve the health of our community, and delivers programs and services to help achieve that goal. The Community Benefit 2018 Report and 2019 Plan describes much of this work. This report meets requirements in California state law (Senate Bill 697) that not-for-profit hospitals produce an annual community benefit report and plan. Dignity Health produces these reports and plans for all of its hospitals, including those in Arizona and Nevada. 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 2018 (FY18), Sequoia Hospital provided $19,407,325 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, and other community benefits. The hospital also incurred $52,534,657 in unreimbursed costs of caring for patients covered by Medicare.

Sequoia Hospital’s Community Board reviewed, approved and adopted the Community Benefit 2018 Report and 2019 Plan at its November 7, 2018 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at (650) 367.5995 or Marie.Violet@DignityHealth.org.

William Graham
President

Betty Till
Chairperson, Board of Directors
# Table of Contents

At-a-Glance Summary .................................................. 3

Mission, Vision and Values ........................................... 5

Our Hospital and the Community Served .......................... 6

**Community Assessment and Planning Process**
- Community Health Needs Assessment ......................... 8
- CHNA Significant Health Needs ................................. 8
- Creating the Community Benefit Plan ....................... 10

**2018 Report and 2019 Plan**
- Report and Plan Summary ....................................... 12
- Community Grants Program .................................... 16
- Anticipated Impact ................................................ 17
- Planned Collaboration ........................................... 17
- Financial Assistance for Medically Necessary Care .......... 17
- Program Digests .................................................. 18

Economic Value of Community Benefit ........................... 33

**Appendices**
- Appendix A: Community Board and Committee Rosters .... 34
- Appendix B: Other Programs and Non-Quantifiable Benefits 37
- Appendix C: Financial Assistance Policy Summary .......... 39
At-a-Glance Summary

| Community Served | Sequoia Hospital serves the cities in central and southern San Mateo County, including the cities of Belmont, San Carlos, Redwood City, Atherton, Portola Valley, Woodside, and portions of Menlo Park, Foster City, and San Mateo. In San Mateo County, minorities are underrepresented, and most residents have incomes higher than the national average but that figure is tempered by the cost to live here. |
| Economic Value of Community Benefit | $19,407,325 in patient financial assistance, unreimbursed costs of Medicaid, community health improvement services, community grants and other community benefits. $52,534,657 in unreimbursed costs of caring for patients covered by Medicare. |
| 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). Those needs are: • Diabetes • Childhood obesity • Health care access & delivery • Behavioral health • Fitness, diet, & nutrition • Heart disease & stroke • Unintended injuries • Housing & homelessness • Cancer • Violence & abuse • Transportation & traffic • Alzheimer’s disease & dementia • Emotional well-being • Respiratory conditions • Communicable diseases • Birth outcomes |
| FY18 Actions to Address Needs | • Diabetes Empowerment Education Program (DEEP) – Evidence based educational program designed to engage community residents in self-management practices for prevention and control of diabetes. • LiveWell Program – Free monthly blood pressure and glucose screenings for older adults in the community by a registered nurse. • Make Time for Fitness Program – encourages healthy eating, physical activity, anti-bullying and avoidance of tobacco products, alcohol, and marijuana amongst elementary school students. • Sequoia Community Care – seeks to improve the health of “at risk” patients by ensuring a successful transition from hospital to home after discharge. The program enables older adults to remain independent at home and avoid unnecessary re-hospitalizations for chronic conditions. • Matter of Balance Program – A six week evidence based structured group intervention that emphasizes practical strategies to reduce fear of falling and increase activity levels. • Dignity Health Sequoia Hospital Community Grants Program $131,153 – In awarding community grants, Dignity Health actively partners with non-profit organizations working to improve health status and quality of life in the communities we serve. |
| Planned Actions for FY19 | For FY19, the hospital plans to continue all FY18 programs. |

This document is publicly available at www.dignityhealth.org/sequoia. Sequoia uses social media platforms, such as Facebook and Twitter, to promote and distribute this important information externally to our broader community. The metrics of key Community Benefit programs also are included in the Annual Mission Integration report distributed to select hospital and Dignity Health committees.

Written comments on this report can be submitted to Dignity Health Sequoia Hospital, Health & Wellness Department, 170 Alameda de las Pulgas, Redwood City, CA 94062.

To send comments or questions about this report, please visit www.dignityhealth.org/sequoia/contact-us and select the “CHNA comments” in the drop-down menu.
MISSION, VISION AND VALUES

Sequoia Hospital is a part of Dignity Health, a non-profit health care system made up of more than 60,000 caregivers and staff who deliver excellent care to diverse communities in 21 states. Headquartered in San Francisco, Dignity Health is the fifth largest health system in the nation.

At Dignity Health, we unleash the healing power of humanity through the work we do every day, in hospitals, in other care sites and the community.

Our Mission

We are committed to furthering the healing ministry of Jesus. We dedicate our resources to:
- Delivering compassionate, high-quality, affordable health services;
- Serving and advocating for our sisters and brothers who are poor and disenfranchised; and
- Partnering with others in the community to improve the quality of life.

Our Vision

A vibrant, national health care system known for service, chosen for clinical excellence, standing in partnership with patients, employees, and physicians to improve the health of all communities served.

Our Values

Dignity Health is committed to providing high-quality, affordable healthcare to the communities we serve. Above all else we value:

- **Dignity** – Respecting the inherent value and worth of each person.
- **Collaboration** – Working together with people who support common values and vision to achieve shared goals.
- **Justice** – Advocating for social change and acting in ways that promote respect for all persons.
- **Stewardship** – Cultivating the resources entrusted to us to promote healing and wholeness.
- **Excellence** – Exceeding expectations through teamwork and innovation.
OUR HOSPITAL AND THE COMMUNITY SERVED

About Sequoia Hospital

Dignity Health Sequoia Hospital is an accredited, not-for-profit community hospital providing innovative and exceptional health care for generations of Bay Area residents. Sequoia’s Heart and Vascular Institute is a nationally known pioneer in advanced cardiac care, affiliated with the Cleveland Clinic Heart and Vascular Institute. Sequoia has received national recognition from Healthgrades for superior patient safety and was named as one of America’s top 100 hospitals for cardiac care.

The hospital is located at 170 Alameda de las Pulgas in Redwood City, California, and serves the communities of San Mateo County. It affiliated with Dignity Health in 1996 under a management agreement and became wholly owned by Dignity Health in January 2008. Our facility is licensed for 208 beds, is served by more than 900 employees, and benefits from more than 500 physicians on staff offering a full range of medical, surgical and specialty programs.

Description of the Community Served

Sequoia Hospital serves the cities in central and southern San Mateo County, including the cities of Belmont, San Carlos, Redwood City, Atherton, Portola Valley, Woodside, and portions of Menlo Park, Foster City, and San Mateo. A summary description of the community is below, and additional details can be found in the CHNA report online.

San Mateo County (SMC) residents are healthier than in many other places. However, the data also demonstrates that preventable diseases are on the rise and so we must do more to prevent these diseases from occurring in the first place. It also shows that health is not distributed evenly across the population, and there are many communities that still do not experience good health and a high quality of life.

Average salaries, adjusted for inflation, are currently well above the California average. The cost of living is higher in SMC than almost anywhere else in the nation. A single parent with two children must earn approximately $78,000 annually to meet the family’s basic needs. SMC housing rental and childcare costs exceed the state’s average. A total of 18.9 percent of SMC adults live below 200 percent of the Federal Poverty Level.

The proportion of adults aged 60 and older is expected to roughly double over the next four decades. As of the 2000 census adults aged 60 and older in San Mateo County, represented 16.4% of the county’s total population. By the year 2040, it is projected that the number of adults 60+ will increase to 28.7% of the county’s total population.

- Total Population: 559,332
- White – Non-Hispanic: 48.3%, Black/African American – Non-Hispanic: 2.2%, Hispanic or Latino 22.8%, Asian/Pacific Islander: 21.9%, All Others: 4.7%
- Median Income: $137,101
- Unemployment: 3.2%
- No High School Diploma: 9.8%
- Medicaid: 14.7% (Does not include individuals dually-eligible for Medicaid and Medicare.)
- Uninsured: 2.8%
One tool used to assess health need is the Community Need Index (CNI) created and made publicly available by Dignity Health and Truven Health Analytics. The CNI analyzes data at the zip code level on five factors known to contribute or be barriers to health care access: income, culture/language, education, housing status, and insurance coverage. Scores from 1.0 (lowest barriers) to 5.0 (highest barriers) for each factor are averaged to calculate a CNI score for each zip code in the community. Research has shown that communities with the highest CNI scores experience twice the rate of hospital admissions for ambulatory care sensitive conditions as those with the lowest scores.
COMMUNITY ASSESSMENT AND PLANNING PROCESS

The hospital engages in multiple activities to conduct its community benefit and 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; using five core principles to guide planning and program decisions; measuring and tracking program indicators and impact; and engaging the Sequoia Hospital Board, Community Advisory Committee and other stakeholders in the development of an annual community benefit plan and triennial Implementation Strategy.

Community Health Needs Assessment

The significant needs that form the basis of the hospital’s community health programs were identified in the most recent Community Health Needs Assessment (CHNA), which was adopted in May 2016.

The hospital conducts a CHNA at least every three years to inform its community health strategy and program planning. The CHNA report contains several key elements, including:

- Description of the assessed community served by the hospital;
- Description of assessment processes and methods, including: the data used; how the hospital solicited and took into account input from a public health department, members or representatives of medically underserved, low-income and minority populations; and the process and criteria used in identifying significant health needs and prioritizing them;
- Presentation of data, information and assessment findings, including a prioritized list of identified significant community health needs;
- Community resources (e.g., organizations, facilities and programs) potentially available to help address identified needs; and
- Discussion of impacts of actions taken by the hospital since the preceding CHNA.

CHNA Significant Health Needs

The community health needs assessment identified the following significant community health needs. The needs the hospital is not addressing are noted in the description:

<p>| Prioritized 2016 significant health needs by overall score (greatest to least) |</p>
<table>
<thead>
<tr>
<th>Health Needs</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>There is a higher rate of diabetes among adults in the county compared to the Healthy People 2020 target. Blacks and low-income county residents disproportionately report having been diagnosed with diabetes. Diabetes is the eighth leading causes of death in the county.</td>
</tr>
<tr>
<td>Childhood obesity</td>
<td>The rates of obese, overweight, and/or at-risk of overweight children are higher in the county compared to California. Childhood obesity disproportionately affects Latino, Black, and American Indian children in the county.</td>
</tr>
<tr>
<td>Health care access &amp; delivery</td>
<td>The proportion of county residents who report visiting a doctor for a routine check-up has been trending downward. Residents giving the lowest ratings to health care access in the county were low-income, Latino, and those without a postsecondary education.</td>
</tr>
<tr>
<td>Topic</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Behavioral health</td>
<td>The percentage of adults who report mental and emotional problems is rising, and binge drinking among young adult males is trending up. Suicide is one of the top 10 leading causes of death in the county.</td>
</tr>
<tr>
<td>Fitness, diet, &amp; nutrition</td>
<td>The percentage of county adults who exhibit healthy behaviors has dropped over time. Adults who are low-income, Black, and Latino report fair or poor access to affordable fresh produce more often than those of other ethnicities in the county.</td>
</tr>
<tr>
<td>Heart disease &amp; stroke</td>
<td>County mortality rates for these cerebrovascular diseases (such as stroke) are higher than Healthy People 2020 targets. Diseases of the heart are the leading cause of death in the county, and stroke is the fourth leading cause of death. There are rising percentages of county adults reporting high cholesterol and hypertension.</td>
</tr>
<tr>
<td>Unintended injuries</td>
<td>Unintended injuries are the sixth leading cause of death in the county. The community is concerned with the rate of older adults who are injured due to falls, especially because of the county’s increasing proportion of older adult residents.</td>
</tr>
<tr>
<td>Housing &amp; homelessness</td>
<td>Housing is less affordable in San Mateo County than in the rest of the Bay Area and housing prices are again on the rise. Although homelessness in the county has decreased, Blacks, Latinos, and veterans are disproportionately represented in the county’s homeless population.</td>
</tr>
<tr>
<td>Cancer</td>
<td>Cancer is the second leading cause of death in the county.</td>
</tr>
<tr>
<td>Violence &amp; abuse</td>
<td>Although by almost all statistical measures, violence (including violent crime) and abuse are trending down in the county, the community’s perceptions have not changed over time. The rate of child abuse among Black families in the county is much higher than the state rate. In addition, an emerging issue is human trafficking.</td>
</tr>
<tr>
<td>Transportation &amp; traffic</td>
<td>A lack of transportation disproportionately affects low-income, less-educated, Latino, and Black respondents.</td>
</tr>
<tr>
<td>Alzheimer's disease &amp; dementia</td>
<td>The proportion of older adult residents is increasing and the mortality rate from Alzheimer’s is higher in the county compared to California. Alzheimer’s disease is the third leading cause of death in the county.</td>
</tr>
<tr>
<td>Emotional well-being</td>
<td>The percentage of adults experiencing depression and feeling tense, worried, or anxious is higher amongst some ethnic groups and low income households. Adult life satisfaction in the county has been declining over time.</td>
</tr>
<tr>
<td>Oral/dental health</td>
<td>Sequoia Hospital has chosen not to address this 2016 CHNA significant identified health need. This need is beyond the capacity, resources and competencies of the hospital and is being addressed by other organizations in the community.</td>
</tr>
<tr>
<td>Respiratory conditions</td>
<td>Adult asthma prevalence has increased substantially over time and now exceeds the Healthy People 2020 objective.</td>
</tr>
<tr>
<td>Communicable diseases</td>
<td>There has been a rise in the incidence rate of tuberculosis in the county over the past decade, and it remains higher than the state average. Pneumonia and influenza combined are the seventh leading cause of death in the county.</td>
</tr>
</tbody>
</table>
Income & employment
Sequoia Hospital has chosen not to address this 2016 CHNA significant identified health need. This need is beyond the capacity, resources and competencies of the hospital and is being addressed by other organizations in the community.

Climate Change
Sequoia Hospital has chosen not to address this 2016 CHNA significant identified health need. This need is beyond the capacity, resources and competencies of the hospital and is being addressed by other organizations in the community.

Arthritis
Sequoia Hospital has chosen not to address this 2016 CHNA significant identified health need. This need is beyond the capacity, resources and competencies of the hospital and is being addressed by other organizations in the community.

Sexually Transmitted Infections
Sequoia Hospital has chosen not to address this 2016 CHNA significant identified health need. This need is beyond the capacity, resources and competencies of the hospital and is being addressed by other organizations in the community.

Birth outcomes
Black and Asian/Pacific Islander women are more likely to have low birthweight babies than women of other ethnicities in the county.

Additional detail about the needs assessment process and findings can be found in the CHNA report, which is publicly available at [www.dignityhealth.org/bayarea/locations/sequoia/about-us/community-benefits](http://www.dignityhealth.org/bayarea/locations/sequoia/about-us/community-benefits) or upon request at the hospital’s Community Health office.

Creating the Community Benefit Plan

Rooted in Dignity Health’s mission, vision and values, Sequoia Hospital is dedicated to improving community health and delivering community benefit with the engagement of its management team, Sequoia Hospital Board and Community Advisory Committee (CAC). The board and committee are composed of community members who provide stewardship and direction for the hospital as a community resource (see Appendix A). These parties review community benefit plans and program updates prepared by the hospital’s community health director and other staff.

As a matter of Dignity Health policy, the hospital’s community health and community benefit programs are guided by five core principles. All of our initiatives relate to one or more of these principles:

- Focus on Disproportionate Unmet Health-Related Needs
- Emphasize Prevention
- Contribute to a Seamless Continuum of Care
- Build Community Capacity
- Demonstrate Collaboration

The 2016 CHNA will be the guide for actively planning programs. Programs will be evaluated throughout the year utilizing input from our community advisors, partners, newly published data and our own program outcome measures data. This dynamic approach will allow us to respond to identified needs by revising program strategies and adding enhancements on a regular basis.

It is our intention that programs that we sponsor for both the broad and vulnerable communities will contribute to containing the growth of community health care costs. Prevention is a driver of our programs. The CNI, Community Health Needs Assessment and relationships with community service
organizations help us identify vulnerable populations with disproportionate unmet health needs that have a high prevalence or severity for a particular health concern that we can address with a program or activity.
## 2018 Report and 2019 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 FY18 and planned activities for FY19, with statements on anticipated impacts, planned collaboration, and patient financial assistance for medically necessary care. Program Digests provide detail on select programs’ goals, measurable objectives, expenses and other information.

This report specifies planned activities consistent with the hospital’s mission and capabilities. The hospital may amend the plan as circumstances warrant. For instance, changes in significant community health needs or in community assets and resources directed to those needs may merit refocusing the hospital’s limited resources to best serve the community.

### Report and Plan Summary

<table>
<thead>
<tr>
<th>Health Need: Diabetes</th>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Empowerment Education Program (DEEP)</td>
<td>Evidence based educational program designed to engage community residents in self-management practices for prevention and control of diabetes.</td>
<td>☒</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>Blood glucose meter instruction</td>
<td>Helps empower patients with the self-management tools and educational resources they need to prevent and control a variety of diabetic issues.</td>
<td>☒</td>
<td>☒</td>
<td></td>
</tr>
<tr>
<td>LiveWell Program</td>
<td>Free quarterly glucose screenings for older adults provided by an RN at community centers. The program includes monitoring screening results, one-on-one counseling and referrals to physicians for abnormal results.</td>
<td>☒</td>
<td>☒</td>
<td></td>
</tr>
</tbody>
</table>

**Anticipated Impact:** Prevent and/or reduce adverse health outcomes related to diabetes.

<table>
<thead>
<tr>
<th>Health Need: Childhood obesity</th>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Make Time for Fitness Program</td>
<td>Make Time for Fitness (MTF) encourages healthy eating, physical activity, anti-bullying and avoidance of tobacco products, alcohol, and marijuana amongst elementary school students.</td>
<td>☒</td>
<td>☒</td>
<td></td>
</tr>
</tbody>
</table>

**Anticipated Impact:** Teach school-aged children to recognize and adopt behaviors for lifelong good health.
### Health Need: Health care access and delivery

<table>
<thead>
<tr>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial assistance for uninsured/underinsured and low income</td>
<td>The hospital provides discounted and free health care to qualified individuals, following Dignity Health’s Financial Assistance Policy.</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Sequoia Community Care</td>
<td>Program designed to offer services and community resources to allow older adults discharged from Sequoia Hospital to recover safely and healthfully in their homes.</td>
<td>☒</td>
<td>☒</td>
</tr>
</tbody>
</table>

**Anticipated Impact:** Ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care.

### Health Need: Behavioral Health

<table>
<thead>
<tr>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Parents Support Group</td>
<td>A weekly peer support group open to the community and facilitated by an RN. The drop-in group empowers new mothers and fathers to thrive in their new roles as parents. Once a month a Licensed Marriage &amp; Family Therapist facilitates the group to discuss post-partum mood adjustments.</td>
<td>☒</td>
<td>☒</td>
</tr>
</tbody>
</table>

**Anticipated Impact:** Teach participants to recognize and adopt behaviors for lifelong good health.

### Health Need: Fitness, diet, & nutrition

<table>
<thead>
<tr>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maturing Gracefully</td>
<td>A collaborative program with the Belmont Library and Friends of the Library, to host lectures about senior health issues.</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>LiveWell Program</td>
<td>Coaching by a registered nurse to help clients monitor and achieve lifestyle changes.</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Make Time for Fitness Program</td>
<td>Make Time for Fitness (MTF) encourages healthy eating, physical activity, anti-bullying and avoidance of tobacco products, alcohol, and marijuana amongst elementary school students.</td>
<td>☒</td>
<td>☒</td>
</tr>
<tr>
<td>Gentle Tai Chi Chuan (Sponsor)</td>
<td>Program emphasizes and practices mindful moves in a non-judgmental harmonious setting. This class is for beginning newcomers (partnership with the City of San Carlos).</td>
<td>☒</td>
<td>☒</td>
</tr>
</tbody>
</table>

**Anticipated Impact:** Teach participants to recognize and adopt behaviors for lifelong good health.
### Health Need: Heart disease & stroke

<table>
<thead>
<tr>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>LiveWell Program</td>
<td>Free monthly blood pressure screenings for older adults held at 6 sites in the community by a RN. The program includes monitoring screening results, one-on-one counseling and referrals to physicians for abnormal results.</td>
<td>☒</td>
<td>☒</td>
</tr>
</tbody>
</table>

**Anticipated Impact:** To detect early signs of disease and refer for treatment to primary care physician to reduce the incidences of adverse effects.

### Health Need: Unintended injuries

<table>
<thead>
<tr>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matter of Balance Program</td>
<td>A six week evidence based structured group intervention that emphasizes practical strategies to reduce fear of falling and increase activity levels.</td>
<td>☒</td>
<td>☒</td>
</tr>
</tbody>
</table>
| Dignity Health Concussion Network | There are 3 components:  
1. Barrow Brainbook delivers concussion education to high school athletes through an online learning module.  
2. ImPACT assessment tool provides pre- and post-concussion test results so athletic trainers and coaches can determine if it is safe for an athlete to return to play.  
3. Telehealth software gives athletic trainers and physicians 24/7 access to a consultation with a neurologist specializing in concussion and traumatic brain injuries. | ☒           | ☒            |

**Anticipated Impact:** To prevent and/or reduce adverse health outcomes of an unintended injury.

### Health Need: Violence & Abuse

<table>
<thead>
<tr>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sequoia Hospital Human Trafficking Awareness</td>
<td>Community partnerships and information dissemination</td>
<td>☒</td>
<td>☒</td>
</tr>
</tbody>
</table>

**Anticipated Impact:** Develop strategic partnerships between community-based organizations and Sequoia Hospital. Resources are leveraged and address priority health issues in creative ways that have a direct, positive, measureable and lasting impact on the health of identified individuals in our community.
<table>
<thead>
<tr>
<th>Health Need: Transportation &amp; traffic</th>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ride service</td>
<td>Complimentary transportation is available for inpatients and ED patients who are unable to obtain their own ride within a reasonable timeframe after discharge is ordered.</td>
<td>☒ ☒</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Anticipated Impact:** Increase access to ride services

<table>
<thead>
<tr>
<th>Health Need: Respiratory conditions</th>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Better Breather’s Club</td>
<td>Community-based educational opportunities and support to persons with chronic pulmonary disease and their families, friends, and support persons.</td>
<td>☒ ☒</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Anticipated Impact:** To prevent and/or reduce adverse health outcomes related to respiratory conditions.

<table>
<thead>
<tr>
<th>Health Need: Birth Outcomes</th>
<th>Strategy or Activity</th>
<th>Summary Description</th>
<th>Active FY18</th>
<th>Planned FY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lactation Education Services</td>
<td>Calm Line for breastfeeding advice answered by International Board Certified Lactation Consultant® RNs. Provide a Family Room, which is available to the community to feed and weigh their babies.</td>
<td>☒ ☒</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing Mothers Counsel (host site)</td>
<td>The organization’s goal is to help mothers and their babies enjoy a relaxed and happy feeding relationship.</td>
<td>☒ ☒</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Anticipated Impact:** Improve maternal, infant and child health.
Community 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 in the communities we serve. Grant funds are used to deliver services and strengthen service systems, to improve the health and well-being of vulnerable and underserved populations.

In FY18, the hospital awarded 5 grants totaling $131,153. Below is a complete listing of FY18 grant projects; some projects may be described elsewhere in this report.

<table>
<thead>
<tr>
<th>Grant Recipient</th>
<th>Project Name and Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peninsula Conflict Resolution Center</td>
<td>Pacific Islander Health Ambassador Program – educates on the importance of fitness, diet, nutrition, and accessing health care in order to reduce diabetes and pre-diabetes in a community that suffers disproportionately from this chronic disease.</td>
<td>$20,000</td>
</tr>
<tr>
<td>United through Education (Familias Unidas)</td>
<td>United through Education (Familias Unidas) – promotes the progress of our community by teaching parents how to support and help their children achieve success, focusing on the academic, social emotional, and physical aspects of a healthy life. During this nine-week training course, families learn strategies and are provided with the necessary tools to improve their children’s education and creating healthy habits to live a healthy lifestyle. This comprehensive course empowers the families academically, socially and emotionally</td>
<td>$20,000</td>
</tr>
<tr>
<td>Peninsula Volunteers, Inc. (PVI)</td>
<td>Supportive Services at Home Collaborative – The collaboration of PVI Meals on Wheels, Samaritan House, Sequoia Village, and Home Helpers Home Care aligns with Sequoia Hospital’s community benefit initiative. Each of the partners offers a unique service and contributes to a seamless continuum of care, ensuring clients/patients will receive increased access to medical care, nutritious meals, and ADL and IADL support, in-home safety assessment, socialization and more.</td>
<td>$20,000</td>
</tr>
<tr>
<td>LifeMoves</td>
<td>Health Advocacy Outreach Program – connects unsheltered, medically fragile homeless or marginally housed individuals with critically needed support services</td>
<td>$45,000</td>
</tr>
<tr>
<td>Peninsula Volunteers, Inc. (PVI)</td>
<td>Memory Care and Caregiver Collaborative –</td>
<td>$26,153</td>
</tr>
</tbody>
</table>
consists of four partner agencies, the Alzheimer’s Association, Family Caregiver Alliance, Peninsula Volunteers Rosener House Adult Day Services, and Catholic Charities Adult Day Services, San Mateo County working together to address the needs of persons living with dementia and their caregivers by providing education, support, referrals, respite, and direct care services for the increasing number of families dealing with dementia.

**Anticipated Impact**

The anticipated impacts of the hospital’s activities on significant health needs are summarized above, and for select program initiatives are stated in the Program Digests on the following pages. Overall, the hospital anticipates that actions taken to address significant health needs will: improve health knowledge, behaviors, and status; increase access to needed and beneficial care; and help create conditions that support good health. The hospital is committed to measuring and evaluating key initiatives. The hospital creates and makes public an annual Community Benefit Report and Plan, and evaluates impact and sets priorities for its community health program in triennial Community Health Needs Assessments.

**Planned Collaboration**

The creation of collaborations with community-based organizations, leadership in local networks and advocacy initiatives, local capacity-building initiatives is integral to Sequoia Hospital’s Community Benefit activities. Sequoia Hospital is a member of the Hospital Consortium of San Mateo County, which supports and advocates for many important health initiatives in the community. Members of Sequoia Hospital’s leadership team support many of our community’s not-for profit organizations by serving on boards, supporting fundraising events and participating in initiatives led by the organizations. Strong collaborative relationships with community partners enable us to share resources and demonstrate ongoing commitment to our shared goals. Collaborators on specific initiatives are listed in the program digests that follow. Sequoia Hospital brings a broad, community-wide perspective to community benefit work as a champion for the health of the entire community.

**Financial Assistance for Medically Necessary Care**

Sequoia Hospital delivers compassionate, high quality, affordable health care and advocates for members of our community who are poor and disenfranchised. In furtherance of this mission, the hospital provides financial assistance to eligible patients who do not have the capacity to pay for medically necessary health care services, and who otherwise may not be able to receive these services. A plain language summary of the hospital’s Financial Assistance Policy is in Appendix C. The amount of financial assistance provided in FY18 is listed in the Economic Value of Community Benefit section of this report.
The hospital notifies and informs patients and members of the community about the Financial Assistance Policy in ways reasonably calculated to reach people who are most likely to require patient financial assistance. These include:

- providing a paper copy of the plain language summary of the Policy to patients as part of the intake or discharge process;
- providing patients a conspicuous written notice about the Policy at the time of billing;
- posting notices and providing brochures about the financial assistance program in hospital locations visible to the public, including the emergency department and urgent care areas, admissions office and patient financial services office;
- making the Financial Assistance Policy, Financial Assistance Application, and plain language summary of the Policy widely available on the hospital’s web site;
- making paper copies of these documents available upon request and without charge, both by mail and in public locations of the hospital; and
- providing these written and online materials in appropriate languages.

**Program Digests**

The following pages include Program Digests describing key programs and initiatives that address one or more significant health needs in the most recent CHNA report. The digests include program descriptions and intervention actions, statements of which health needs are being addressed, any planned collaboration, and program goals and measurable objectives.
### Diabetes Empowerment Education Program (DEEP)

| Significant Health Needs Addressed | ☒ Diabetes  
|                                   | ☒ Childhood Obesity  
|                                   | ☒ Health Care Access & Delivery  
|                                   | ☒ Fitness, Diet, & Nutrition  
|                                   | ☒ Heart Disease & Stroke  
|                                   | ☐ Unintended injuries  |

| Core Principles Addressed | ☒ Focus on Disproportionate Unmet Health-Related Needs  
|                          | ☒ Emphasize Prevention  
|                          | ☒ Contribute to a Seamless Continuum of Care  
|                          | ☒ Build Community Capacity  
|                          | ☒ Demonstrate Collaboration  |

| 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. Provided in partnership with Health Services Advisory Group (HSAG).  |

| Community Benefit Category | A1-a Community Health Education - Lectures/Workshops  |

#### FY 2018 Report

| Program Goal / Anticipated Impact | To improve and maintain the quality of life of persons who are pre-diabetic or diabetic;  
|                                 | To prevent complications and incapacities;  
|                                 | To increase physical activity;  
|                                 | To develop self-care skills;  
|                                 | To improve the relationships between patients and health care providers;  
|                                 | To utilize available resources.  |

| Measurable Objective(s) with Indicator(s) | Objectives  
|                                           | Increase knowledge of diabetes self-management  
|                                           | Indicators  
|                                           | Participant Pre- and Post-Test  |

| Intervention Actions for Achieving Goal | Offered the DEEP program at 3 sites in English and Spanish.  
|                                       | Additional staff certified as a DEEP Peer Educator  |

| Planned Collaboration | San Carlos Adult Community Center  
|                      | Twin Pines Senior & Community Center  
|                      | Familias Unidas  
|                      | HSAG  |

| Program Performance / Outcome | Tests and evaluations were given to HSAG for compilation. Results showed an increase in self-care measures, coping with diabetes and diabetes knowledge.  |

| Hospital's Contribution / Program Expense | Resources committed to program: staff, supplies & facility space.  
|                                          | $1,391  |

#### FY 2019 Plan

| Program Goal / Anticipated Impact | To improve and maintain the quality of life of persons who are pre-diabetic or diabetic;  
|                                 | To prevent complications and incapacities;  
|                                 | To increase physical activity;  
|                                 | To develop self-care skills;  |
- To improve the relationships between patients and health care providers;
- To utilize available resources.

<table>
<thead>
<tr>
<th>Measurable Objective(s) with Indicator(s)</th>
<th>Objectives</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Increase knowledge of diabetes self-management</td>
<td>Participant Pre- and Post-Test</td>
</tr>
</tbody>
</table>

| Intervention Actions for Achieving Goal | Offer the DEEP program in English and Spanish to the Pacific Islander and Latino community. |

<table>
<thead>
<tr>
<th>Planned Collaboration</th>
<th>HSAG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Familias Unidas</td>
</tr>
<tr>
<td></td>
<td>Pacific Islander Health Ambassador Program</td>
</tr>
</tbody>
</table>
### LiveWell Program

| Significant Health Needs Addressed | ✗ Diabetes  
|                                      | □ Childhood Obesity  
|                                      | ✗ Health Care Access & Delivery  
|                                      | ✗ Fitness, Diet, & Nutrition  
|                                      | ✗ Heart Disease & Stroke  
|                                      | □ Unintended injuries  |

| Core Principles Addressed | ✗ Focus on Disproportionate Unmet Health-Related Needs  
|                          | ✗ Emphasize Prevention  
|                          | ✗ Contribute to a Seamless Continuum of Care  
|                          | ✗ Build Community Capacity  
|                          | ✗ Demonstrate Collaboration  |

| Program Description | Health screening program conducted monthly at 6 sites in the community. Services include free screenings for blood pressure and diabetes, monitoring screening results, one-on-one counseling and referrals to physicians for abnormal results. |

| Community Benefit Category | A2-d Community-Based Clinical Services - Immunizations/Screenings |

### FY 2018 Report

| Program Goal / Anticipated Impact | To detect early signs of disease, to monitor and refer for treatment to primary care physician, and to reduce the incidences of adverse effects. |

| Measurable Objective(s) with Indicator(s) | Objectives  
|                                          | ▪ Identify and manage, via early intervention, older adults with cardiovascular and/or endocrine risk factors.  
|                                          | Indicators  
|                                          | ▪ # of screening encounters  
|                                          | ▪ # of referrals made to primary care physician  
|                                          | ▪ # of participants who received one-on-one counseling  
|                                          | ▪ Annual client survey  |

| Intervention Actions for Achieving Goal | Offered no cost screenings for, hypertension and diabetes, as well as counseling and routine monitoring at 6 senior/community center sites.  
|                                          | Provided initial assessment and monthly on-going monitoring of screening results.  
|                                          | Provided individual counseling with RN.  
|                                          | Referred to physicians for abnormal results.  
|                                          | Provided stroke awareness information, medication cards and monitored their use at monthly blood pressure screenings.  
|                                          | Maintained records from client self-reported outcomes of physician visits following screening and counseling.  
|                                          | Provided phone check-in’s with identified clients. |

| Planned Collaboration | Host sites  
|                       | Veterans Memorial Senior Center  
|                       | Adaptive Physical Education Center  
|                       | Twin Pines Senior & Community Center  
|                       | San Carlos Adult Community Center |
| Program Performance / Outcome | Little House Activity Center  
| Fair Oaks Adult Activity Center |
| 959 screenings provided  
41 referrals made to primary care physician  
233 of participants received one-on-one counseling  
100% of those surveyed were very/extremely likely to recommend this service to a friend.  
79% of those surveyed shared their results with their doctor.  
20% of those surveyed said that their physician made changes to their medications, diet and/or exercise recommendations based on the results of the screening. |
| Hospital's Contribution / Program Expense | Resources committed to program: staff & supplies.  
$38,922 |

**FY 2019 Plan**

| Program Goal / Anticipated Impact | To detect early signs of disease, to monitor and refer for treatment to primary care physician, and to reduce the incidences of adverse effects. |
| Measurable Objective(s) with Indicator(s) | **Objectives**  
Identify and manage, via early intervention, older adults with cardiovascular and/or endocrine risk factors.  
**Indicators**  
# of screening encounters  
# of referrals made to primary care physician  
# of participants who received one-on-one counseling  
Annual client survey |
| Intervention Actions for Achieving Goal | Offer no cost screenings for hypertension and diabetes at senior/community center sites.  
Initial assessment and monthly on-going monitoring of screening results  
Individual counseling with RN  
Referrals to physicians for abnormal results  
Maintain records from client self-reported outcomes of physician visits following screening and counseling.  
RN phone check-in with identified clients. |
| Planned Collaboration | Host sites  
Veterans Memorial Senior Center  
Adaptive Physical Education Center  
Twin Pines Senior & Community Center  
San Carlos Adult Community Center  
Little House Activity Center  
Fair Oaks Adult Activity Center |
<table>
<thead>
<tr>
<th>Make Time for Fitness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Significant Health Needs Addressed</strong></td>
</tr>
<tr>
<td>☐ Diabetes</td>
</tr>
<tr>
<td>☒ Childhood Obesity</td>
</tr>
<tr>
<td>☐ Health Care Access &amp; Delivery</td>
</tr>
<tr>
<td>☒ Fitness, Diet, &amp; Nutrition</td>
</tr>
<tr>
<td>☒ Heart Disease &amp; Stroke</td>
</tr>
<tr>
<td>☐ Unintended injuries</td>
</tr>
</tbody>
</table>

| **Core Principles Addressed** |
| ☒ Focus on Disproportionate Unmet Health-Related Needs |
| ☒ Emphasize Prevention |
| ☐ Contribute to a Seamless Continuum of Care |
| ☒ Build Community Capacity |
| ☒ Demonstrate Collaboration |

| **Program Description** |
| Make Time for Fitness (MTF) is a program designed to address healthy eating, physical activity, anti-bullying and avoidance of tobacco products, alcohol, and marijuana among 4th grade students attending RCSD schools. |

| **Community Benefit Category** |
| A1: Community Health Education |
| F7: Community Building Activities |

| **FY 2018 Report** |
| **Program Goal / Anticipated Impact** |
| Teach school-aged children to recognize and adopt behaviors for lifelong good health. |

| **Measurable Objective(s) with Indicator(s)** |
| **Objectives** |
| ▪ Increase knowledge of healthy eating, physical activity, anti-bullying and avoidance of tobacco products, alcohol, and marijuana. |
| **Indicators** |
| ▪ Student Pre- and Post-Test |
| ▪ Teacher evaluation |

| **Intervention Actions for Achieving Goal** |
| ▪ Make Time for Fitness Walking Courses - special walking courses installed by Sequoia Hospital and maintained by every elementary school in Redwood City. Courses are utilized by PE+, teachers, parents and community members. |
| ▪ Hosted a SF Giant Player school assembly for the Sequoia High School Health Career Academy. Topic: Empowering youth to compassionately engage the needs of their community through action and service. |
| ▪ A Make Time for Fitness planning and implementation committee was convened by the director of Health & Wellness. Members included community partners, and volunteers. |
| ▪ SUHSD students, from 3 high schools, were selected by teachers to serve as leaders of interactive learning stations at MTF (Tobacco products, alcohol, and marijuana, Yoga, Friendship Fitness, 3 out of 5 Breakfast, and Water First). |
| ▪ Hosted Make Time for Fitness Fieldtrip at Red Morton Park (May 17, 2018). |

<p>| <strong>Planned Collaboration</strong> |
| ▪ Redwood City School District |
| ▪ Sequoia Union High School District |
| ▪ Redwood City Parks, Recreation and Community Services |</p>
<table>
<thead>
<tr>
<th>Program Performance / Outcome</th>
<th>Student pre &amp; post online test results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Yoga: 8% knowledge increase</td>
</tr>
<tr>
<td></td>
<td>- Tobacco products, alcohol, and marijuana: 20% knowledge increase</td>
</tr>
<tr>
<td></td>
<td>- “3 out of 5” healthy balanced breakfast: 9% knowledge increase</td>
</tr>
<tr>
<td></td>
<td>- Water First: 4% knowledge increase</td>
</tr>
</tbody>
</table>

**Student/Teacher Evaluations**

- 85% of student said the program was good/awesome
- 92% of students said they learned a lot/a good amount
- 70% of teachers liked the program and thought it was good/excellent.
- 100% of teachers stated the students learned from the Make Time for Fitness curriculum.

**Hospital's Contribution / Program Expense**

Resources committed to program: staff, supplies, food, and transportation

<table>
<thead>
<tr>
<th>FY 2019 Plan</th>
</tr>
</thead>
</table>

**Program Goal / Anticipated Impact**

Teach school-aged children to recognize and adopt behaviors for lifelong good health.

**Measurable Objective(s) with Indicator(s)**

**Objectives**

- Increase knowledge of healthy eating, physical activity, anti-bullying and avoidance of tobacco products, alcohol, and marijuana.

**Indicators**

- Student behavior change survey
- Teacher evaluation

**Intervention Actions for Achieving Goal**

- Make Time for Fitness Walking Courses will be utilized by RCSD PE+ program, teachers, parents and community members.
- A Make Time for Fitness planning and implementation committee will be convened by the director of Health & Wellness. Members will include community partners, volunteers, and members of the RCSD wellness committee.
- Host annual Make Time for Fitness event at Red Morton Park (May 23, 2019)

**Planned Collaboration**

- Redwood City School
- Sequoia Union High School District
- Redwood City Parks, Recreation and Community Services
- Sodexo Education
- San Mateo County Tobacco Prevention Program
- UC Cal Fresh Nutrition Education Program
- San Mateo County Public Health Nutrition
- Safe Routes to School California
- Sequoia Healthcare District – PE+ Program
- Dairy Council of California
## Significant Health Needs Addressed

| ☒ Diabetes |
| ☐ Childhood Obesity |
| ☒ Health Care Access & Delivery |
| ☒ Fitness, Diet, & Nutrition |
| ☒ Heart Disease & Stroke |
| ☒ Unintended injuries |

## Core Principles Addressed

- ☒ Focus on Disproportionate Unmet Health-Related Needs
- ☒ Emphasize Prevention
- ☒ Contribute to a Seamless Continuum of Care
- ☒ Build Community Capacity
- ☒ Demonstrate Collaboration

## Program Description

A transitional care program designed to offer services and community resources, up to 30 days post-discharge, to allow older adults from Sequoia Hospital to recover safely and healthfully in their homes.

## Community Benefit Category

A3: Health Care Support Services

## FY 2018 Report

### Program Goal / Anticipated Impact

To promote the successful recuperation of older adults after they return home from the hospital.

### Measurable Objective(s) with Indicator(s)

#### Objectives
- Reduce the readmission rate of older adults referred to the SCC.
- Improve the overall physical, emotional and spiritual health of older adults discharged from Sequoia Hospital.

#### Indicators
- Sequoia Hospital 30 day readmission rates for SCC patients
- # of patients referred
- # of patients utilizing community based services
- Patient satisfaction survey

### Intervention Actions for Achieving Goal

- **Identification** – Promoted inter-departmental communication to identify potential candidates to be identified by care coordinators, social workers, hospitalists, spiritual care chaplains or the Transition Care Nurse (TCN) at Sequoia Hospital.
- **Bed-side visit** – TCN conducted a bedside visit to assess patient’s health status/needs.
- **Discharge** – Within 24-48 hours of discharge, the TCN assisted patient with community services (meals, transportation, private duty caregiver assistance, social services, etc.) and if necessary conducted one home visit.
- **Telephone monitoring** – RN scheduled calls with specific goals and structured questioning.
- **Tracking** – NaviHealth

### Planned Collaboration

Sequoia Community Care is based on collaboration. Our community partners include but are not limited to:
- Peninsula Family Service (PFS)
- Jewish Family and Children’s Services (Seniors at Home)
| Program Performance / Outcome | 116 patients referred to TCN* (February – June 2018)  
|                               | Services provided to patients (Dec 2017 – June 2018)  
|                               | o 41 patients each received 8-10 days of adult day services  
|                               | o 23 patients each received 21 days of meals  
|                               | o 46 patients each received 20 hours of private home duty care  
| *A full-time TCN was hired |
| Hospital’s Contribution / Program Expense | Resources committed to program: staff & supplies.  
|                                           | $96,662 |

**FY 2019 Plan**

**Program Goal / Anticipated Impact**

To promote the successful recuperation of older adults after they return home from the hospital.

**Measurable Objective(s) with Indicator(s)**

**Objectives**

- Reduce the readmission rate of older adults referred to the SCC.

**Indicators**

- Sequoia Hospital 30 day readmission rates for SCC patients
- # of patients referred
- # of patients utilizing community based services
- Patient satisfaction survey

**Intervention Actions for Achieving Goal**

- **Collaboration** – Coordinate partner collaborative meetings.
- **Identification** – TCN to attend rounds M-F to promote inter-departmental communication to identify potential candidates.
- **Bed-side visit** – TCN to conduct a bedside visit to assess patient’s health status/needs.
- **Discharge** – Within 24-48 hours of discharge, the TOC will assist patients with community services (meals, transportation, private duty caregiver assistance, social services, etc.) and if necessary conduct one home visit.
- **Telephone monitoring** – TCN to schedule calls with specific goals and structured questioning.
- **Tracking** – utilize NaviHealth to track referrals

**Planned Collaboration**

Sequoia Community Care is based on collaboration. Our community partners include but are not limited to:

- Peninsula Family Service (PFS)
- Jewish Family and Children’s Services (Seniors at Home)
- Peninsula Volunteers (Meals on Wheels)
- Peninsula Volunteers (Rosener House Adult Day Services)
- Samaritan House
- Alzheimer’s Association
- Catholic Charities CYO (San Carlos Adult Day Services)
- Family Caregiver Alliance
- Sequoia Village, a program of Villages of San Mateo County
- Rebuilding Together Peninsula
- Center for Independence of Individuals with Disabilities (CID)
- Home Safety Services
- LifeMoves
- Fair Oaks Community Center
- San Mateo Behavioral Health & Recovery Services (BHRS)
- Pathways Home Health, Hospice & Private Duty
- Philips Lifeline
### Matter of Balance

**Significant Health Needs Addressed**
- ☐ Diabetes
- ☐ Childhood Obesity
- ☐ Health Care Access & Delivery
- ☒ Fitness, Diet, & Nutrition
- ☐ Heart Disease & Stroke
- ☒ Unintended injuries

**Core Principles Addressed**
- ☒ Focus on Disproportionate Unmet Health-Related Needs
- ☒ Emphasize Prevention
- ☐ Contribute to a Seamless Continuum of Care
- ☐ Build Community Capacity
- ☒ Demonstrate Collaboration

**Program Description**
The evidence based program is a collaboration between Sequoia Hospital and Stanford Health Care. Matter of Balance acknowledges the risk of falling but emphasizes practical coping skills to reduce this concern. Trained facilitators conduct eight two-hour sessions that includes simple exercises to increase strength and balance. Offered in English and Spanish.

**Community Benefit Category**
A1-a Community Health Education - Lectures/Workshops

### FY 2018 Report

**Program Goal / Anticipated Impact**
Reduce the fear of falling and increase activity levels among older adults who manifest this concern.

**Measurable Objective(s) with Indicator(s)**

- **Objectives**
  - Learn to view falls and fear of falling as controllable
  - Set realistic goals for increasing activity
  - Increase strength and balance

- **Indicators**
  - Sit to Stand test

**Intervention Actions for Achieving Goal**
- 8 Matter of Balance classes were held in Sequoia Hospital’s core service area.
- Certified as a Matter of Balance/Lay Leader Model training center

**Planned Collaboration**
- Twin Pines Senior & Community Center
- San Carlos Adult Community Center
- Little House Activity Center
- Fair Oaks Adult Activity Center
- Stanford Health Care
- Fall Prevention Coalition of San Mateo County

**Program Performance / Outcome**
- 82% of participants showed improvement in the Sit to Stand test

**Hospital’s Contribution / Program Expense**
Resources committed to program: staff, supplies & facility space.
$14,893

### FY 2019 Plan

**Program Goal / Anticipated Impact**
Reduce the fear of falling and increase activity levels among older adults who manifest this concern.

**Measurable Objective(s) with Indicator(s)**

- **Objectives**
  - Learn to view falls and fear of falling as controllable
<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
<th>Offer 4-6 Matter of Balance classes in Sequoia Hospital’s core service area.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned Collaboration</td>
<td>Twin Pines Senior &amp; Community Center</td>
</tr>
<tr>
<td></td>
<td>San Carlos Adult Community Center</td>
</tr>
<tr>
<td></td>
<td>Little House Activity Center</td>
</tr>
<tr>
<td></td>
<td>Fair Oaks Adult Activity Center</td>
</tr>
<tr>
<td></td>
<td>Stanford Health Care</td>
</tr>
<tr>
<td></td>
<td>Fall Prevention Coalition of San Mateo County</td>
</tr>
<tr>
<td>Significant Health Needs Addressed</td>
<td>☐ Diabetes</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Core Principles Addressed</td>
<td>☒ Focus on Disproportionate Unmet Health-Related Needs</td>
</tr>
<tr>
<td>Program Description</td>
<td>Guided by the Dignity Health Human Trafficking Response Program, the hospital has convened a multi-disciplinary Human Trafficking Taskforce to support education and awareness programs for both Sex and Labor Trafficking. Monthly communications including newsletters, posters, seminars and an annual Awareness Day are provided to educate staff, visitors, volunteers, community members and our partner organizations.</td>
</tr>
<tr>
<td>Community Benefit Category</td>
<td>A5-Hu Initiative - Human Trafficking Community Response</td>
</tr>
<tr>
<td><strong>FY 2018 Report</strong></td>
<td><strong>Human Trafficking Community Response</strong></td>
</tr>
<tr>
<td>Program Goal / Anticipated Impact</td>
<td>Human Trafficking takes place “Before Our Very Eyes” and the goal is to educate all participants regarding red flags, interventions and community resources.</td>
</tr>
<tr>
<td>Measurable Objective(s) with Indicator(s)</td>
<td><strong>Objectives:</strong></td>
</tr>
<tr>
<td></td>
<td>• To increase awareness of all staff, visitors, providers, patients, contractors to the issue of human trafficking in our community, state, nation and world.</td>
</tr>
<tr>
<td></td>
<td>• To educate all on our role in the prevention and treatment of this social and healthcare situation.</td>
</tr>
<tr>
<td></td>
<td>• To identify local resources and to promote communication and collaboration among them.</td>
</tr>
<tr>
<td></td>
<td><strong>Indicators:</strong></td>
</tr>
<tr>
<td></td>
<td>• # of attendees ( # of staff reached, # of community organizations attending, # of community members, visitors, volunteers)</td>
</tr>
<tr>
<td></td>
<td>• Evaluations of attendees at all events</td>
</tr>
<tr>
<td>Intervention Actions for Achieving Goal</td>
<td>• To hold at least one annual hospital wide event for staff and community members in partnership with Dignity Health Human Trafficking Response Program and community organizations.</td>
</tr>
<tr>
<td></td>
<td>• Send members of the Sequoia Human Trafficking Task Force to the Dignity Health Response Human Trafficking Task Force in San Diego, CA.</td>
</tr>
<tr>
<td></td>
<td>• Hold Sequoia Human Trafficking Taskforce monthly meetings.</td>
</tr>
<tr>
<td></td>
<td>• Distribute Blue Bracelet Bands for Human Trafficking Awareness</td>
</tr>
<tr>
<td>Planned Collaboration</td>
<td>Collaborators:</td>
</tr>
<tr>
<td></td>
<td>• San Mateo County Human Trafficking Initiative</td>
</tr>
</tbody>
</table>
| Program Performance / Outcome | • The Sequoia Human Trafficking Taskforce sponsored 2 campus wide Human Trafficking Awareness events with speakers and educational booths in January and June of 2018.  
• Sequoia Hospital Taskforce Co-Chair joined and attended monthly meetings of the San Mateo County Human Trafficking Initiative formed by the San Mateo County Board of Supervisors.  
• Co-chair of the Sequoia Hospital Human Trafficking Taskforce and the Director and Founder of Bay Area Anti-Trafficking Coalition presented to the Sequoia Hospital Community Advisory Committee in April 2018.  
• Four members of the Sequoia Human Trafficking Task Force attended the Dignity Health Response Human Trafficking Task Force in San Diego, CA.  
• The Sequoia Human Trafficking Taskforce held monthly meetings.  
• Distributed Blue Bracelet Bands for Human Trafficking Awareness. |
| Hospital’s Contribution / Program Expense | $53,164  
Staff, facility space, funds to other agencies |

**FY 2019 Plan**

**Program Goal / Anticipated Impact**

Human Trafficking takes place “Before Our Very Eyes” and the goal is to educate all participants regarding red flags, interventions and community resources.

| Measurable Objective(s) with Indicator(s) | Objectives:  
• To increase awareness of all staff, visitors, providers, patients, contractors to the issue of human trafficking in our community, state, nation and world.  
• To educate all on our role in the prevention and treatment of this social and healthcare situation.  
• To identify local resources and to promote communication and collaboration among them.  

Indicators:  
• # of attendees ( # of staff reached, # of community organizations attending, # of community members, visitors, volunteers)  
• Evaluations of attendees at all events. |
<table>
<thead>
<tr>
<th>Intervention Actions for Achieving Goal</th>
<th>Collaborators:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To hold at least one annual hospital wide event for staff and community members in partnership with Dignity Health Human Trafficking Response Program and community organizations. (January 2019)</td>
<td>• Dignity Health Response Program</td>
</tr>
<tr>
<td>• Sequoia Hospital Taskforce Co-Chair to attend monthly meetings of the San Mateo County Human Trafficking Initiative.</td>
<td>• San Mateo County Human Trafficking Initiative</td>
</tr>
<tr>
<td>• Hold Sequoia Human Trafficking Taskforce monthly meetings.</td>
<td>• Bay Area Anti-Trafficking Coalition</td>
</tr>
<tr>
<td>• Distribute Blue Bracelet Bands for Human Trafficking Awareness</td>
<td>• Before Our Very Eyes, Redwood City, CA</td>
</tr>
<tr>
<td>• Present to the Sequoia Hospital Community Board</td>
<td>• San Mateo County Sheriff’s Office</td>
</tr>
<tr>
<td>• Send Sequoia Hospital Taskforce members to Dignity Health/Trust Summit in Mesa, Arizona August 2018</td>
<td>• Redwood City Police Department</td>
</tr>
<tr>
<td>• Monthly communications with hospital staff</td>
<td>• Freedom House</td>
</tr>
<tr>
<td></td>
<td>• Human Trafficking National Hotline</td>
</tr>
<tr>
<td></td>
<td>• County Child Welfare Agency (24/7 hotline)</td>
</tr>
<tr>
<td></td>
<td>• County Welfare Agency for Vulnerable Adults (24/7 hotline)</td>
</tr>
<tr>
<td></td>
<td>• CORA (24/7 Helpline for Local DV shelter)</td>
</tr>
<tr>
<td></td>
<td>• San Mateo County Pride Center</td>
</tr>
<tr>
<td></td>
<td>• Keller Center</td>
</tr>
<tr>
<td></td>
<td>• San Mateo County Office of Immigrant Support and Coordination Services</td>
</tr>
<tr>
<td></td>
<td>• Rape Crisis Center (24-Hour Hotline)</td>
</tr>
</tbody>
</table>
**ECONOMIC VALUE OF COMMUNITY BENEFIT**

The economic value of community benefit for patient financial assistance is calculated using a cost-to-charge ratio, and for Medicaid and other categories of community benefit using a cost accounting methodology.

Sequoia Hospital  
Complete Summary - Classified Including Non Community Benefit (Medicare)  
For period from 7/1/2017 through 6/30/2018

<table>
<thead>
<tr>
<th>Benefits for Vulnerable</th>
<th>Persons Served</th>
<th>Net Benefit</th>
<th>% of Org. Expenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial Assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid *</td>
<td>4,986</td>
<td>16,474,386</td>
<td>5.7</td>
</tr>
<tr>
<td>Community Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A - Community Health Improvement Services</td>
<td>540</td>
<td>156,059</td>
<td>0.1</td>
</tr>
<tr>
<td>E - Cash and In-Kind Contributions</td>
<td>62</td>
<td>131,302</td>
<td>0.0</td>
</tr>
<tr>
<td>F - Community Building Activities</td>
<td>8</td>
<td>7,672</td>
<td>0.0</td>
</tr>
<tr>
<td>G - Community Benefit Operations</td>
<td>0</td>
<td>77,659</td>
<td>0.0</td>
</tr>
<tr>
<td>Totals for Community Services</td>
<td>610</td>
<td>372,692</td>
<td>0.1</td>
</tr>
<tr>
<td>Totals for Vulnerable</td>
<td>6,826</td>
<td>18,014,310</td>
<td>6.2</td>
</tr>
</tbody>
</table>

| Benefits for Broader Community      |               |                 |                    |
| Community Services                  |               |                 |                    |
| A - Community Health Improvement Services | 8,960        | 309,307         | 0.1                |
| B - Health Professions Education    | 159           | 967,966         | 0.3                |
| E - Cash and In-Kind Contributions  | 1,044         | 8,358           | 0.0                |
| F - Community Building Activities   | 137           | 107,384         | 0.0                |
| Totals for Community Services       | 10,300        | 1,393,015       | 0.5                |
| Totals for Broader Community        | 10,300        | 1,393,015       | 0.5                |
| Totals - Community Benefit          | 17,126        | 19,407,325      | 6.7                |
| Medicare                            | 25,314        | 52,534,657      | 18.0               |
| Totals with Medicare                | 42,440        | 71,941,982      | 24.7               |

Net Benefit equals costs minus any revenue from patient services, grants or other sources.

* The hospital was required to record some Medicaid Provider Fee revenue and expense in FY18 that was attributable to FY17 services. If all FY17 Medicaid Provider Fee revenue and expense had been recorded in FY17, the hospital's FY18 net benefit for Medicaid would have been $14,285,862.
APPENDIX A: COMMUNITY BOARD AND COMMITTEE ROSTERS

Sequoia Hospital Community Board

Chair
Betty Till
Executive Coach, LifeWork Solutions

Vice Chair
Steven San Filippo
Partner, Sensiba, San Filippo, LLP

Secretary
Timothy C. Wu
Zoological Society of San Francisco

President, Medical Staff
Dieter Bruno, MD (July 2018 – Present)
Peninsula Urology Center

Jim Torosis, MD (July 2016 – June 2018)
Peninsula Gastroenterology Medical Group

Hospital President
Bill Graham
Sequoia Hospital

Members
Mojdeh Talebian, MD
Dignity Health Medical Network

Sandra Ferrando
Community Advocate

Dan Rengstorff, MD
Peninsula Gastroenterology Medical Group

Kim Hurst
Community Member

Jason Wong, MD
Medical Director of Health Services
Samaritan House

Pam Ginocchio
International Lawyer

Tykia Warden
Interim Executive Director of Development
San Mateo County Community Colleges Foundation
Community Advisory Committee

Betty Till, Chair  
*Liaison to Sequoia Hospital Board*  
Executive coach, LifeWork Solutions

John Baker, Ed.D.  
Superintendent, Redwood City School District

Christopher Beth  
Director, Redwood City Parks, Recreation and Community Services Department

Joanie Cavanaugh  
Founder & Principal  
Cavanaugh Creative Group

Sandra Coolidge  
President of Philanthropy  
Pathways Home Health & Hospice

Ted Hannig  
Attorney, Hannig Law Firm

Diane Howard  
Vice Mayor, City of Redwood City

Susan Houston  
Director, Older Adult Services  
Peninsula Family Service

Scott McMullin  
Board Chair, Villages of San Mateo County

Melissa Platte  
Executive Director  
Mental Health Association of San Mateo County

Melanie Rogers  
Principal/HR Director, DES Architects

John Tucker  
Business Agent, AFSCME Council 57

Paula Uccelli  
Sequoia Hospital Foundation Hon Board
Jason Wong, M.D.
Medical Director of Health Services
Samaritan House

Bill Graham
Liaison to Sequoia Hospital Board
President
Sequoia Hospital

David Cowell
Director, Mission Integration, Spiritual and Palliative Care
Sequoia Hospital

Paul Richardson
President
Sequoia Hospital Foundation

Marie Violet
Director, Health & Wellness
Sequoia Hospital

Tricia Halimah
Manager of Community Health
Sequoia Hospital
APPENDIX B: OTHER PROGRAMS AND NON-QUANTIFIABLE BENEFITS

The hospital delivers a number of community programs 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.

Community Building
- Redwood City School District Wellness Advisory committee member – a forum for school district staff, community organizations, community members, parents, and youth to collaborate on efforts to keep students healthy.
- SUHSD Wellness Advisory Council (WAC) executive committee member - Students, parents, teachers, health professionals, counseling/administrative staff, and Board members work alongside community members and outside agencies to discuss all aspects of wellness.
- 70 Strong Advisory committee member– initiative of Sequoia Healthcare District in partnership with Peninsula Family Service.
- Friends and Family CPR program (Partnership with Sequoia Healthcare District) – classes for 9th grade high school students, expectant parents, and new parents.
- The San Mateo County Paratransit Coordinating Council (PCC) member - an organization dedicated to improving the quality and availability of paratransit services in San Mateo County.
- Fall Prevention Coalition of San Mateo County steering committee member - informs, collaborates, and raises awareness to prevent falls among older adults living in our community.
- San Mateo County Breastfeeding Advisory committee member - promotes and supports breastfeeding as the optimal infant feeding method through pre- and post-natal education, advocacy, and community outreach
- Tobacco Education Coalition member – advocating policy change to support a tobacco-free San Mateo County.
- Healthy Community Collaborative of San Mateo County (co-chair) - A group of San Mateo County organizations formed in 1995 for the purpose of identifying and addressing the health needs of the community by conducting a triennial Community Health Needs Assessment.

Health & Wellness Department
Health & Wellness Center is department of Sequoia Hospital located in downtown Redwood City. The center has been open to the public since 1993 and provides Sequoia Hospital’s community health programs to the broader community and to the vulnerable.
- The Big Lift library (location) -- a box of books where anyone can borrow a book (or two) and bring back another to share.
- Grief Support Group Living with Loss (in partnership with Pathways Home Health & Hospice) -- A group designed to explore and make sense of the complex and overwhelming feelings that may accompany grief.
- Food Addicts in Recovery Anonymous (FA) (host site) – An international fellowship of men and women who have experienced difficulties in life as a result of the way they used to eat.
- Prostate Support Group (host site) – Open to men of all ages and their families and close friends who want to learn more about prostate health.
Stanford Healing Partners (host site) – Healing Partners provide free Healing Touch sessions to men and women diagnosed with cancer who are under the active care of a physician.

Nursing Mothers Counsel (host site) – The organization’s goal is to help mothers and their babies enjoy a relaxed and happy feeding relationship.

Health professional education
Sequoia contributes to the long-term health of our community by providing student training in many health care disciplines.

- Clinical Chaplaincy Training Program
- Sterile Processing Training Program
- Pharmacy Training Program
- Physical Therapy Training Program
- Radiology Training Program
- Palliative Care Training Program
- ER - Paramedic Intern & EMT Training Program
- Physician Assistant Training Program
- SFSU/Canada Nursing Program
- University of San Francisco Nursing Program
APPENDIX C: FINANCIAL ASSISTANCE POLICY SUMMARY

Dignity Health’s Financial Assistance Policy describes the financial assistance programs available to uninsured or under-insured patients who meet certain income requirements to help pay for medically necessary hospital services provided by Dignity Health. An uninsured patient is someone who does not have health coverage, whether through private insurance or a government program, and who does not have the right to be reimbursed by anyone else for their hospital bills. An underinsured patient is someone who has health coverage, but who has large hospital bills that are not fully covered by their insurance.

Free Care
• If you are uninsured or underinsured with a family income of up to 200% of the Federal Poverty Level you may be eligible to receive hospital services at no cost to you.

Discounted Care
• If you are uninsured or underinsured with an annual family income between 200-350% of the Federal Poverty level, you may be eligible to have your bills for hospital services reduced to the highest amount reasonably expected to be paid by a government payer, which is usually the amount that Medicare would pay for the same services.
• If you are uninsured or underinsured with an annual family income between 350-500% of the Federal Poverty level you may be eligible to have your bills for hospital services reduced to the Amount Generally Billed, which is an amount set under federal law that reflects the amount that would have been paid to the hospital by private health insurers and Medicare (including co-pays and deductibles) for the medically necessary services.

If you are eligible for financial assistance under our Financial Assistance Policy you will not be required to pay more than the Amount Generally Billed described above. If you qualify, you may also request an interest-free extended payment plan. You will never be required to make advance payment or other payment arrangements in order to receive emergency services.

Free copies of the hospital’s Financial Assistance Policy and financial assistance application forms are available online at your hospital’s website listed below or at the hospital Admitting areas located near the main entrance. (Follow the signs to “Admitting” or “Registration”). Copies of these documents can also be mailed to you upon request if you call Patient Financial Services at the telephone number listed below for your hospital.

Traducción disponible: You may also obtain Spanish and other language translations of these documents at your hospital’s website, in your hospital’s Admitting area, or by calling your hospital’s telephone number.

Dignity Health Financial Counselors are available to answer questions, provide information about our Financial Assistance Policy and help guide you through the financial assistance application process. Our staff is located in the hospital’s Admitting area and can be reached at the telephone number listed below for your hospital.

Sequoia Hospital 170 Alameda de las Pulgas, Redwood City, CA 94062 | Financial Counseling 650-367-5551 | Patient Financial Services 888-488-7667 |www.dignityhealth.org/sequoia/paymenthelp