Dignity Health
Sequoia Hospital

Sequoia Hospital

Community Benefit Report 2014
Community Benefit Implementation Plan 2015

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A message from Glenna Vaskelis, President/CEO of Sequoia Hospital, and Arthur J. Faro, Board Chair of Sequoia Hospital.

The **Hello humankindness** campaign launched by Dignity Health is a movement ignited and based on the proven idea that human connection, be it physical, verbal, or otherwise, leads to better health. At Dignity Health the comprehensive approach to community health improvement recognizes the multi-pronged effort needed to meet immediate and pressing needs, to partner with and support others in the community, and to invest in efforts that address the social determinants of health.

At Sequoia Hospital we share a commitment to improve the health of our community and have offered programs and services to achieve that goal. The 2014 Annual Report and 2015 Plan for Community Benefit fulfills section 501 (r) of the Patient Protection and Affordable Care Act, where each hospital must complete a community health needs assessment every three years and develop a community health implementation plan to document how it will address the significant health needs of the community. We are proud to provide this report as a continuation of the work we have done over the past 64 years to better the health of the communities we serve.

In addition, California State Senate Bill 697 requires not-for-profit hospitals to annually report its community benefit efforts and measurable objectives as well as its plans for the coming year. Encouraged and mandated by its governing body, Dignity Health hospitals comply with both mandates at all of its facilities, including those in Nevada and Arizona, and is proud of the outstanding programs and services that have been offered to improve the health of the communities we serve.

In fiscal year 2014, Sequoia Hospital provided in financial assistance, community benefit, and unreimbursed patient care. Including the unreimbursed cost of caring for patients covered by Medicare, the total expense was $46,759,453.

Dignity Health's Sequoia Hospital Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their November 5, 2014 meeting.

Thank you for taking the time to review our report and plan. If you have any questions, please contact us at 650.367.5998.

Glenna L. Vaskelis
President
Sequoia Hospital
Sr. VP, Operations, Bay Area, Dignity Health

Arthur J. Faro
Board Chair
Sequoia Hospital Board of Directors

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EXECUTIVE SUMMARY

Dignity Health Sequoia Hospital, founded in 1950, is located at 170 Alameda de las Pulgas, Redwood City, CA. It affiliated with Dignity Health in 1996 under a management agreement and became wholly owned by Dignity Health in January 2008. The facility has 189 licensed beds and the average daily census in FY 2014 was 56 (not including our 11 nursery beds). Our hospital is celebrating the future by rebuilding a state-of-the art medical campus including a new 148,000 sq.ft. pavilion with 104 beds, expanded emergency services and larger, private patient rooms. Grand opening celebrations on the first weekend in May included a special community event hosted by Sequoia Hospital. More than 1,300 community members attended the full afternoon Family Day, which included special educational activities, music, food, raffles and tours of the new pavilion. Sequoia Hospital staff and Sequoia Community Partners taught about stroke awareness, diabetes, car seat safety, concussion awareness, cardiovascular risk reduction and fall prevention and brought back the famously popular Teddy Bear Clinic for children. Sequoia has a staff of 936 employees and professional relationships with more than 500 local physicians. Major hospital services include a Heart and Vascular Institute, Birth Center, and Emergency Services.

During FY 2014, Sequoia Hospital's Community Benefit Plan focused on programs and initiatives serving both broad and vulnerable communities with disproportionate unmet health related needs (DUHN) within our primary service area. Priority areas are Chronic Disease Prevention and Management, Healthy Aging in Place, Child/Youth Healthy Development and Community Building.

The Chronic Disease Prevention and Management priority is addressed by adult screenings, health education and vaccines program. Screenings include monthly blood pressure checks by a registered nurse at seven adult and community centers and include one-on-one education and physician referrals for those with abnormal blood pressure. Seasonal flu, pneumococcal and Tdap vaccine clinics are conducted in the community, focusing on high risk populations. We have identified the Belmont Library as an excellent site for delivering a well-attended "Maturing Gracefully" monthly health lecture series for older adults. Falls are a key issue leading to hospitalization, loss of independence and death among seniors. In 2003 the San Mateo County Fall Prevention Task Force was created by Sequoia Hospital to increase awareness and address the factors that cause falls. The Task Force brings together more than 50 organizations to create and disseminate fall prevention resources.

The rate of diabetes in southern San Mateo County is 9.3 percent and has increased 2.5 times over the past 10 years. The Live Well with Diabetes program addresses this chronic care need of the community. This free program is presented in English and Spanish by trained lay leaders and addresses diabetes management and prevention for those who are at high risk for diabetes, pre-diabetes, those with diabetes and their caregivers. The goal of this program is to improve quality of life for participants by increasing their self-efficacy and avoiding hospital admissions and visits to the emergency room. This program is supported by a collaboration of Sequoia Hospital, Peninsula Family Service, Samaritan House and Cañada College.

Healthy Aging in Place for older adults is addressed by the Sequoia Community Care program (SCC). The SCC program aims to provide effective approaches to better support "*at-risk*" community members to understand and manage their health conditions, access the vast array of community services that can help prevent an expensive health crisis (e.g. hospitalization and/or institutionalized care), and transition safely home when hospitalization does occur.

The Dignity Health Sequoia Hospital Community Grants Program provides funding to nine community-based programs that provide social services to our SCC clients. The collaborative practices of the SCC partners contribute to the success of the program and community building. In April 2014, we received a generous grant from the Gordon and Betty Moore Foundation that allowed us to hire a full-time Transitional Care Nurse and provided training in the evidence based Coleman Model Transitional Care coaching.

Our priority of Child/Youth Healthy Development begins with our support of families during pregnancy and continues with our strong lactation education and New Parent's Support groups. Our Make Time for Fitness

school programs, membership on school district Wellness Committees and county-wide work with Get Healthy San Mateo County Task Force allow us to touch the lives of young children and families in the most high-need areas of Redwood City, as well as across the broader community. Community partnerships and volunteers have continued to expand and enrich the Make Time for Fitness program over the past 15 years. We conducted vaccination clinics at a community school to serve 32 minors which helped the Redwood City School District achieve 100% compliance with the state mandated immunization requirements for 7th grade students. In collaboration with the Sequoia Union High School District (SUHSD) and community partners, Sequoia has participated in CPR training for more than 1500 freshman students and initiated a pilot "Impact Test" program for concussion education and baseline testing.

Sequoia Hospital is effectively able to carry out these community benefit activities with our institutional assets, resources and competencies. Equally important are our strong collaborative relationships with community partners who share resources and demonstrate ongoing commitment to our shared goals. Sequoia Hospital brings a broad, community-wide perspective to community benefit work as a champion for the health of the entire community.

Sequoia Hospital's Community Benefit Implementation Plan for FY 2015 will continue to support and enhance initiatives that address needs identified in the 2013 Community Health Needs Assessment.

The total dollars quantified for Community Benefit in FY 2014 is $46,759,453.

MISSION STATEMENT

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.

ORGANIZATIONAL COMMITMENT

Sequoia Hospital's Organizational Commitment

The development and execution of the Community Benefit Implementation Plan is a priority of the Sequoia Hospital annual strategic plan. Sequoia Hospital's Board of Directors is responsible for approving the Community Benefit Implementation Plan and oversees its development and implementation through the Hospital's Community Advisory Committee (CAC).

The CAC consists of 15 community members representing a wide array of interests and perspectives. The CAC includes two members of the Sequoia Hospital Board of Directors to ensure linkage between the Hospital Board and the CAC. CAC members serve up to two terms of three years each, represent diverse sectors of the community and serve as a catalyst for relationship building and partnering with organizations, businesses, and individuals in the community. (Please see Attachment B for the 2014 Roster of Sequoia Hospital CAC members).

The Hospital president appointed the vice president of community relations/president of the Sequoia Hospital Foundation, and vice president of physician and business development for Sequoia Hospital/chief strategy officer for Dignity Health Bay Area to have administrative responsibility for the Community Benefit Implementation Plan and serve as senior staff to the CAC.

A multidisciplinary team of staff works collaboratively to integrate and implement the Community Benefit Plan. In addition to the individuals mentioned above, the team includes the director of the Sequoia Hospital Health & Wellness Center, the department responsible for implementing community outreach and health education programs. The Health & Wellness coordinator is responsible for data collection, reporting and analysis. The director of mission integration ensures coordination of the Community Benefit Implementation Plan with the Hospital's mission. The budgeting process for Sequoia Hospital's Community Benefit activities is part of the Hospital's annual budget planning led by Sequoia's chief financial officer.

The Sequoia Hospital Health & Wellness staff is responsible for program content and design and for decisions on continuation or termination of programs. The Health & Wellness Center staff brings a broad spectrum of experience and clinical expertise to their work. They include public health practitioners, registered nurses, international board certified lactation consultants, certified childbirth educators, CPR instructors and occupational therapists. Staff from departments of Sequoia Hospital, including the diabetes treatment center, rehabilitation services, sleep center, pharmacy, pulmonary rehabilitation, spiritual care, nursing and nutrition services serve as advisors and respond to requests to participate in implementing community benefit programs.

Advisory to the Health & Wellness staff are members of the Community Advisory Committee (CAC).
The CAC is responsible for approving the proposed Community Benefit priorities and providing broad-level oversight to staff on program content, design, targeting, monitoring and evaluation, as well as program continuation or termination. The CAC meets quarterly and members serve to provide review and oversight for major initiatives and key community benefit programs.

Members of the CAC serve on the Local Review Committee for the annual Dignity Health Sequoia Hospital Community Grants Program. They ensure that the grants program supports the continuum of care in the community offered by other not-for-profit organizations and aligns with Sequoia's strategic plan and community benefit initiatives.

Quarterly CAC meetings include: presentations addressing current community benefit initiatives; highlights and program outcomes from community grants recipients; current community issues for older adults, youth and employers from expert community leaders and Sequoia's strategic plan and building updates. Many CAC members attend and participate in the annual Make Time for Fitness fieldtrip. The 2013 Community Health Needs Assessment was presented to the CAC, and after discussion the members submitted program ideas that have informed the FY 2014 Implementation Plan. In October 2014 the CAC will provide approval of the FY 2014 Community Benefit Report and FY 2015 Implementation Plan.

NON-QUANTIFIABLE BENEFITS

Beyond the dollars spent and numbers served, an equally valuable component of Sequoia Hospital's Community Benefit work is difficult to quantify in our ongoing reporting mechanisms. The creation of collaborations with community-based organizations, leadership in local networks and advocacy initiatives, local capacity-building initiatives, and efforts to sustain the environment are integral to Sequoia's Community Benefit activities.

This past fiscal year, Sequoia Hospital staff continued to play key leadership roles in important local initiatives. Examples of this service and leadership include:

- The director of Sequoia Hospital Health & Wellness Center (H&W) co-chaired the Healthy Community Collaborative of San Mateo County, which conducted the 2013 triennial Community Health Needs Assessment as well as other important county-wide, health-related initiatives. She also participated on School Wellness Committees for the San Carlos, Redwood City, and Sequoia Union High School Districts. She was a member of the Advisory Council of Get Healthy San Mateo County (GHSMC) and San Mateo County Readmission Task Force.

- Sequoia's Lactation Center Nurse Coordinator served on the San Mateo County Breastfeeding Advisory Committee. The Advisory Committee works on the Get Healthy San Mateo County Access & Promotion Strategy to increase the percentage of mothers who exclusively breastfeed their babies beyond the first six months of life.

- Director of H&W served on Sequoia Healthcare District's Community Grants Review Committee and the CEO of the Sequoia Healthcare District served on the Dignity Health Sequoia Hospital Community Grants Local Review Committee, which has enhanced the grant programs of both organizations serving the Sequoia Healthcare District community.

- Sequoia Hospital President serves on the Board of the Hospital Consortium of San Mateo County (past chair), which supports and advocates for many important health initiatives in the community, including a stroke awareness campaign. Sequoia Hospital contributed a total of $40,000 to the Hospital Consortium this past year. The hospital president, along with other members of Sequoia Hospital's leadership team, support many of our community's not-for-profit organizations by serving on boards, attending fundraising events and participating in initiatives led by the organizations. These not-for-profit organizations include Pathways Home Health, Hospice & Private Duty, Second Harvest Food Bank, StarVista, Mental Health Association of San Mateo County – Cedar Street Apartments Board, Shelter Network, Sequoia YMCA, HIP Housing, San Carlos Adult Community Center and others. The hospital president has served on the Board of the Redwood City/San Mateo County Chamber of Commerce for 17 years and was chair in 2009.

- Since 2008, Dignity Health has been dedicated to assisting MedShare as they work to improve the environment and health care through the efficient recovery and redistribution of surplus medical supplies and equipment to underserved health care facilities in developing countries. Sequoia Hospital was the first Dignity Health hospital in the Bay Area to begin the MedShare Program; during FY 2014 Sequoia Hospital donated 2,888 lbs. of supplies and equipment.

  In transitioning to the new Pavilion, much cleaning and purging had to be done of items accumulated in the existing hospital over many years; every effort was made to either reuse or recycle items; "DUMP THE JUNK" Days were scheduled in conjunction with "SHOP AND DROP" so that all departments could evaluate items to be tossed or for possible use elsewhere in the hospital.

  In addition the tobacco free policy has been revised and reinforced by the facilities director and the safety committee in conjunction with administration to ensure the cleanliness of our environment within the community.

COMMUNITY

San Mateo County (SMC), located on the San Francisco Peninsula, is made up of 20 cities and towns, bordered by the city and county of San Francisco on the north, the San Francisco Bay on the east, Santa Clara County (Silicon Valley) on the south, and the Pacific Ocean on the west. Residents are offered a mix of urban development, redwood forests and one of the best-reserved coastlines in the world.

SMC's population was 719,476 in 2010 and is expected to increase 10 percent from 2010-2050. Older adults will make up nearly 30 percent of the population by the year 2030. SMC is among the richest counties in ethnic diversity. Over the next several decades, the White population is expected to decrease (nearly 50 percent), while Hispanic and Asian/Pacific Islander populations are expected to increase dramatically. By the year 2050, the ethnic makeup of the county is projected to be 38 percent Hispanic, 32 percent Asian/Pacific Islander, 22 percent White, 5 percent African-American and 4 percent other/multi-race.

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 rental and child-care costs exceed the state's average. A total of 18.9 percent of SMC adults live below 200 percent of the Federal Poverty Level.

Dignity Health hospitals define the "community" as the primary geographic area served by the hospital, representing 80% of hospital in-patient discharges. The chart below represents Sequoia Hospital's Core Service Area (CSA) 2014. The CSA is a subset of the primary geographic area and used for the purposes of strategic planning.

ZIP Code	ZIP City Name	St	Inpatients Count	%	ZIP Name	ZIP City St	Count	Inpatients %	
94070	San Carlos	CA	801	11.80%	94402	San Mateo	CA	109	1.61%
94061	Redwood City	CA	710	10.46%	94027	Atherton	CA	87	1.28%
94062	Redwood City	CA	618	9.10%	94010	Burlingame	CA	85	1.25%
94002	Belmont	CA	431	6.35%	94019	Half Moon Bay	CA	75	1.10%
94025	Menlo Park	CA	417	6.14%	94401	San Mateo	CA	73	1.08%
94063	Redwood City	CA	405	5.97%	94301	Palo Alto	CA	68	1.00%
94404	San Mateo	CA	298	4.39%	94306	Palo Alto	CA	64	.94%
94403	San Mateo	CA	259	3.82%	94028	Portola Valley	CA	50	.74%
94065	Redwood City	CA	189	2.78%	94304	Palo Alto	CA	22	.32%
94303	Palo Alto	CA	144	2.12%					

Sequoia Hospital's Core Service Area is comprised of suburban communities**: Population**: 522,741; **Diversity**: White Non-Hispanic (50.18%); Hispanic (24.10%); Asian & Pacific Islander (18.89%); Black Non-Hispanic (2.66%): 2+ Races Non-Hispanic (3.66%); Other Non-Hispanic (0.33%) American Indian/Alaska Native (0.18%); **Median Household Income**: $99,169 **Uninsured**: 5.66%; **No HS Diploma**: (5.7%); **Renters**: (40.10%); **CNI Score**: 2.8 (mid-need); **Medicaid Patients: Medicaid/Medi-Cal/AHCCCS** (3.75%); **Medicare** (46.87%); **Commercial-PPO/HMO/Fee for Service** (47.68%)**. Unemployment** - San Mateo County 2014 (4.7%).

Sequoia Hospital also utilizes the Community Need Index (CNI), a tool developed by Dignity Health to measure community need in a geographic market and to analyze the degree to which a community faces barriers to health care access. The factors analyzed in the CNI are income, education, language/culture, insurance and housing. Using statistical modeling, the combination of these factors results in a score ranking from one (less needy) to five (most needy). The median CNI score for Sequoia Hospital's primary service area is 2.8(mid need). The communities in Sequoia Hospital's primary service area that are identified with the second highest need (CNI 4) are zip codes 94063 in Redwood City, a close geographic boundary area, and zip code 94303 in East Palo Alto. (See Attachment A for Sequoia's CNI map and scores by zip code.)

Other hospitals within the community that are able to respond to the health needs of the community are Mills-Peninsula Health Services; Menlo Park Surgical Hospital; Lucile Packard Children's Hospital Stanford; Stanford Health Care; Kaiser Permanente, Redwood City and Santa Clara; San Mateo Medical Center, El Camino Medical Center.
San Mateo County is not designated as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP).

COMMUNITY BENEFIT PLANNING PROCESS

Community Health Needs Assessment Process

Sequoia Hospital participated in a community wide assessment process with the Healthy Community Collaborative (HCC) of San Mateo County (SMC) to conduct the 2013 (seventh) edition of **Community Health Needs Assessment: Health & Quality of Life in San Mateo County (CHNA).** Sequoia Hospital has been a member of the HCC since it was convened in 1994. HCC member organizations participating in the 2013 Community Assessment were Stanford Hospital & Clinics; Peninsula Health Care District; SMC Human Service Agency; Seton Medical Center; Sequoia Hospital; Health Plan of San Mateo; SMC Health Department; Mills-Peninsula Health Services; San Mateo Medical Center; Lucile Packard Children's Hospital at Stanford; Hospital Consortium of SMC; and Kaiser Permanente, San Mateo area.

In conducting the 2013 CHNA the goals of the HCC were twofold:

- To produce a functional, comprehensive community health needs assessment that can be used for strategic planning of community programs and as a guideline for policy and advocacy efforts; and
- To promote collaborative efforts in the community and develop collaborative projects based on the data, community input, identified service gaps and group consensus.

The SMC CHNA survey was designed in 1995 to gather information from the population that is not readily available elsewhere, particularly items that do not naturally lend themselves to database collection. In this assessment, community health includes indicators relating to the quality of life, environmental and social factors that influence health. Many questions in this survey were also administered in the 1998, 2001, 2004, and/or 2008 community assessments. This has allowed for trending of indicators based on longitudinal data and consideration of trends outside the realm of health care.

As with previous assessments, primary research was gathered through a telephone survey of adults in SMC, conducted by Professional Research Consultants, Inc. (PRC) on behalf of the HCC. PRC called a random sample of 1,000 adults. In addition, PRC called oversamples of 300 Coastside residents, 189 North Fair Oaks residents, 85 Black residents, and 150 low-income households. Secondary data collection, analysis and integration was conducted by Donovan Jones, Independent Consultant. The HCC has been fortunate to have the consistent and dedicated oversight provided by Scott Morrow, MD, MPH, MBA, FACPM, Health Officer in the San Mateo County Health System. Dr. Morrow also serves as co-chair of the HCC.

The 2013 Community Assessment affirms that SMC compares favorably to our state and the nation on many health and quality of life measures. For a majority of SMC residents, our community is viewed as a wonderful place to live, work, raise a family and lead a healthy life. However, the report shows that certain segments of the population in SMC still do not experience good health and high quality of life. It also shows that some less than optimal health and quality of life issues are more prevalent in SMC than in other parts of the state and country. Many of the health issues presented are complex and interrelated and require changes in public policy, the environment and the health care system. A key recommendation of the 2013 CHNA is that public policies should prioritize health. The healthy choice should be the easy choice for everyone in SMC.

The following twelve health needs were identified from the primary and secondary data and are all health issues affecting uninsured persons, low-income and minority groups of SMC.

Health Need/Condition	Indicators of Need
Obesity	Percentage of people who are obese is rising
Cardiovascular disease, heart attack and stroke	Percentage of people who exhibit more than one risk factor for cardiovascular disease is not decreasing
Substance use (Alcohol Tobacco & Other Drugs)	Youth drug arrests and binge drinking are rising
Poor oral health	High self-reported lack of access to dental care in youth, and percentage of people who lack dental insurance is rising
Violence	Perception of violence and lack of neighborhood safety is a concern, particularly gang and domestic violence
Infectious disease	Tuberculosis is increasing
Diabetes	Percentage of people with diabetes is continually rising
Poor Mental health	Poor mental health indicators are staying the same or rising, i.e.,

	depression and suicide rates
Cancer	Breast, cervical, colorectal, prostate are not meeting Healthy People 2020 Benchmarks
Births	C-sections are rising and some ethnicities receive inadequate pre-natal care
Asthma & respiratory conditions	Asthma prevalence is worsening
STDs, including HIV-Aids	HIV screening is low among some populations; STDs are on the rise

The 2013 Community Health Needs Assessment of the San Mateo County Community (full report and all previous reports) is available at http://smchealth.org/node/115; www.plsinfo.org/healthysmc/ ; www.hospitalconsort.org. Executive summaries have been distributed to Sequoia Hospital leadership, Hospital and Foundation Board members and our partners who participate in community benefit programs with Sequoia Hospital. The 2013 CHNA and Sequoia Hospital's FY 2014 Implementation Plan is posted on www.sequoiahospital.org and also on the Dignity Health website, www.(to be added.

Assets Assessment

The HCC created an SMC Assets and Opportunities Matrix that includes hospital members outreach efforts and investments. We utilize this to determine the best way to complement each other's outreach and community benefit endeavors in response to the 2013 CHNA results and focus group findings. This document will be updated as we prepare for the 2016 CHNA. We believe that together we can have a collective impact in our community.

Developing Sequoia Hospital's Implementation Plan (Community Benefit Report and Implementation Plan)

In January 2013, the HCC convened a focus group, facilitated by ASR (applied survey research) consisting of 20 members of county coalitions, community based organizations and community leaders representing the communities the hospitals serve. The12 top health needs (see table above) and two sets of cross-cutting drivers (access and prevention & healthy communities) from the newly released 2013 CHNA were presented. Participants provided additional drivers for these health needs, identified assets available to address these health needs and identified additional health needs that they felt were of note. A prioritization process was explained to participants and observers. Each of the top health needs (including Cognitive issues they added and excluding the cross-cutting drivers) would be ranked across four dimensions on a scale of 1 (no/low) to 3 (great/high). The dimensions were:

- Clear disparities or inequities exist
- Presents a prevention/early intervention opportunity
- Impacts quality of life
- Is a priority

Each participant was given an electronic voting device. Their votes were averaged for each of the dimensions, and an overall average score was generated for each health need. The table below lists all of the health needs by their overall score, from greatest to least.

Health Need/Condition	Overall Average Score	Health Need/Condition	Overall Average Score
Diabetes	2.69	Cancer	2.44
Obesity	2.60	Births	2.42
Poor mental health, suicide	2.59	Cognitive issues (Alzheimer's, autistic spectrum)	2.30
Poor oral health	2.57	STDs/HIV-AIDS	2.29
Cardiovascular disease, heart attack, stroke (cerebrovascular disease)	2.56	Asthma & Respiratory Conditions	2.21
Substance abuse (ATOD)	2.56	Infectious disease**	2.10
Violence*	2.56		

*Includes child abuse, domestic violence, elder abuse, gangs, and bullying.
** Includes TB, Hepatitis B/C, pertussis, influenza, etc.

The 2013 CHNA was presented to the Sequoia Hospital CAC by ST Mayer, director of health policy and planning for San Mateo County Health Department and member of the HCC. After a rich discussion, members advised top priorities to be considered in Sequoia's 2014 Community Benefit Plan. Additionally, in

sub-committee advisory meetings, members of the CAC reviewed current programs and advised that these programs and major initiatives remain relevant, are effectively addressing the health needs identified in the 2013 CHNA and should continue with enhancement. A second meeting of the CAC followed with a review of Sequoia Hospital's major community benefit initiatives and program examples. New members actively participated in providing input. The 2013 CHNA will guide Sequoia Hospital's community benefit initiatives for FY 2014-16. The HCC is actively planning for the 2016 CHNA for San Mateo County.

Sequoia Hospital's priority areas and key programs that will address health issues in FY 2015:

1. **Preventing and/or Managing Health Conditions**:
   - Blood pressure, diabetes and cholesterol screenings and education at seven adult and Community Centers
   - Adult immunization clinics for Influenza, Pneumonia, Tetanus, Diphtheria, Pertussis, Shingles
   - Live Well with Diabetes Classes (Spanish and English)
   - Living with Congestive Heart Failure Program
   - Matter of Balance (English and Spanish) community classes
   - Smoking cessation classes
   - Eating for Health: nutrition advisory for community based organization's meal programs in underserved communities.
   - Weight management class at Health & Wellness Center

2. **Healthy Aging in Place:**
   - Sequoia Community Care
   - Dignity Health Sequoia Hospital Community Grants Program for non-profit organizations
   - Tai Chi/Fall Prevention at Twin Pines Adult Community Center
   - Maturing Gracefully monthly lecture series at Belmont Library

3. **Child/Youth Healthy Development:**
   - Lactation Education Center; WIC Partnership for Lactation Consultations
   - New Parents Support Group and Adjusting to Parenthood Group
   - Redwood City School District: Make Time for Fitness Program, school-community partnerships
   - Tdap vaccine clinics for school age children
   - Sequoia Union High School District: Programs for addressing asthma, diabetes, CPR training for teachers and 9th grade students, Impact Test concussion education and baseline testing, Make Time for Fitness leadership training and exploring a cardiac screening program
   - Sequoia Hospital Youth Volunteers/Mentoring

4. **Community Health Improvement:**
   - Sequoia Hospital & Wellness Center:
     - education and support groups; health information and referral; and free space for non-profit groups focusing on community health.

5. **Improving Access to Health Care:**
   - Financial assistance for uninsured/underinsured and low income residents
   - Health professionals education
   - Emergency department physician services for indigent patients

6. **Community Building:**
   - Redwood City/San Mateo County Chamber of Commerce Education Committee
   - Get Healthy San Mateo County Task Force Advisory Council
   - School Wellness committees: San Carlos, Redwood City, Sequoia Union High School District
   - Healthy Community Collaborative of San Mateo County (HCC) Co-Chair
   - San Mateo County Paratransit Coordinating Council member
   - Peninsula Family YMCA and Sequoia YMCA program advisory committee member
   - Cañada College Human Services Advisory Board

- SFSU/ Cañada College Nursing Program
- San Mateo County Breastfeeding Advisory Committee
- San Mateo County Active Access Initiative Collaborative
- Sequoia Healthcare District Community Grants Review Committee member
- Redwood City 2020 Community Partner
- Sequoia Village Planning Committee member
- San Mateo County Readmissions Task Force

Programs will be evaluated throughout the year utilizing in-put 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. The information provided by the 2013 Community Assessment validated that our current major initiatives remain relevant and our programs will continue to address identified unmet health-related needs of our community.

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 Assessments and relationships with community service organizations help us identify vulnerable populations with disproportionate unmet health needs (DUHN) that have a high prevalence or severity for a particular health concern that we can address with a program or activity.

Sequoia Hospital will not be directly focusing on other issues identified in the 2013 CHNA such as mental health, oral health, violence or STD's/HIV-AIDS because they are beyond the scope of our facility and are being addressed by other community based organizations. During FY 2015 we will convene groups of experts in these areas to educate Sequoia on their services so that we will be able to make appropriate and safe referrals and identify opportunities for partnership and inclusion in our community benefit initiatives.

Planning for the Uninsured/Underinsured Patient Population

Sequoia Hospital provides care regardless of the patient's ability to pay. In 2005, the Hospital implemented the Dignity Health Patient Financial Assistance Policy, which was updated in 2008, 2011 and 2012 and is summarized below (a copy of the Summary of Patient Financial Assistance Policy can be found in Attachment C).

Training sessions are held for all personnel in admitting, case management, patient financial services and cashier's office to educate individuals in these departments about proper procedures for implementing the policy and informing patients of their payment options and obligations. Signs describing the "Patient Eligibility Assistance Program" and the "Notice of Community Service Obligation" are prominently displayed in the admitting and case management consultation areas. Additional training is provided whenever updates or changes are made to the policy or its implementation. To notify the general public, Dignity Health has announced the policy widely in local newspapers. Sequoia Hospital provides access to the policy on its website (www.SequoiaHospital.org). Information about the policy is also posted at every point of registration in the Hospital and at the Health & Wellness Center. Staff in the Patient Financial Services department advises patients of the policy and how to apply.

For those patients who are not eligible for government programs, Dignity Health wants to support these individuals by educating them about commercial exchanges, and possible government subsidies. Corporate is providing a health care exchange brochure in English and Spanish which will be widely available throughout the hospital. The brochure directs individuals to a new Dignity Health enrollment website and 24 hour phone support, both available in English and Spanish.

PLAN REPORT AND UPDATE INCLUDING MEASURABLE OBJECTIVES AND TIMEFRAMES

Below are the major initiatives and key community-based programs operated or substantially supported by Sequoia Hospital in FY 2014. Programs intended to be operated in FY 2015 are noted by *. Programs were developed in response to the 2013 Community Health Needs Assessment and are guided by the following five core principles:

- Disproportionate Unmet Health-Related Needs
  Seek to accommodate the needs of communities with disproportionate unmet health-related needs
- Primary Prevention
  Address the underlying causes of persistent health problems
- Seamless Continuum of Care
  Emphasize evidence-based approaches by establishing operational linkages between clinical services and community health improvement activities
- Build Community Capacity
  Target charitable resources to mobilize and build the capacity of existing community assets
- Collaborative Governance
  Engage diverse community stakeholders in the selection, design, implementation and evaluation of program activities

Initiative 1: Chronic Disease Prevention and Management
While many of the health issues presented are complex and interrelated and require changes in public policy, the environment and the health care system, there are many things an individual can do to be healthier.

- Blood Pressure Screening at Senior/Community Centers and Health & Wellness*
- Cholesterol Screenings*
- Diabetes Screenings*
- Adult Immunizations: Flu, Pneumococcal, Tdap, Hep B, Shingles*
- Smoking Cessation Classes*
- Live Well with Diabetes*
- Living with Congestive Heart Failure Program*
- Eating for Health: Nutrition advisory for CBO's meal programs in underserved communities*
- Matter of Balance Classes*

Initiative 2: Healthy Aging in Place
As the fastest-growing population segment, the health and social needs of older adults require increasing attention.

- "Maturing Gracefully" monthly lecture series at Belmont Library*
- Sequoia Community Care *
- Dignity Health Sequoia Hospital Community Grants Program*
  - Peninsula Family Service (case management)
  - Samaritan House Free Clinic Redwood City (Transitional Care Coaching)
  - Peninsula Volunteers (Meals on Wheels)
  - Peninsula Jewish Community Center (Get Up & Go Transportation)
  - Seniors at Home (home care)
  - Catholic Charities CYO (San Carlos Adult Day Center)
  - Peninsula Volunteers (Rosener House)
  - Family Caregiver Alliance (memory and caregiving)
  - Alzheimer's Association (dementia and caregiving)

Initiative 3: Child/Youth Healthy Development
Our children are not doing much better than adults in exhibiting healthy behaviors. This will severely impact their future health.

- Lactation Education Center: Consultations, Family Room, Calm-Line*
- WIC Partnership for staff education and patient consultations*
- New Parents Support Group and Adjusting to Parenthood Class*
- Make Time for Fitness*
- Walking Courses at schools *
- Sequoia Hospital Youth Volunteers/Mentoring*
- CPR Training for 9th Grade Students in Sequoia Union High School District*
- Pilot "Impact Test" for Concussion and Baseline Testing in Sequoia Union High School District*
- Tdap in Redwood City middle schools to achieve 100% compliance with state law AB354*

Initiative 4: Community Building Activities*
Sequoia Hospital is committed to building a healthier community through working collaboratively with community partners and providing leadership as a convener, capacity builder and participating in community-wide health planning.

- Redwood City/San Mateo County Chamber of Commerce Education Committee*
- San Mateo County Fall Prevention Task Force Steering Committee*
- Get Healthy San Mateo County Task Force Advisory Council*
- Member of School Wellness Committees: San Carlos, Redwood City, Sequoia Union High School District*
- Healthy Community Collaborative of San Mateo County (HCC) Co-chair*
- San Mateo County Paratransit Coordinating Council*
- Peninsula Family YMCA Healthy Living Committee and /Sequoia YMCA Program Advisory Committee*
- Cañada College Human Services Advisory Board*
- San Mateo County Breastfeeding Advisory Committee*
- San Mateo County Active Access Initiative Collaborative*
- Sequoia Healthcare District Community Grants Review Committee*
- Redwood City 2020 Community Partner*
- San Mateo County Readmissions Task Force *
- Mental Health Association of San Mateo County – Cedar Street Apartments Board*

Community Benefit Activities Beyond the Core Programs

Beyond Sequoia's core Community Benefit Initiatives and Community Grants Program, the Hospital implements many other ongoing Community Benefit activities that address critical health needs in our community.

The Hospital provides patients at Samaritan House free clinic with lab, radiology, mammography and other outpatient services at no cost. In FY 2014, Sequoia provided $233,884 in free services for 1208 patients. Without Sequoia's support these services would not be available to the clinic's patients. In addition, the Sequoia Hospital Diabetes Treatment Center provides free one-on-one consultations and blood glucose meter instruction for patients who are unable to pay for these services. The Diabetes Treatment Center sends a Certified Diabetes Educator to Samaritan House Free Clinic in Redwood City for 2 hours per week to provide one-on-one diabetes counseling.

Sequoia Hospital's Health & Wellness Center, located in a free-standing building in downtown Redwood City, is an invaluable asset to our community. Most of Sequoia's community health programs and community benefit staff operate out of the center, which offers a comfortable and welcoming environment to all who enter. The center is open to the public and also offers the use of three conference rooms free of charge to community groups including Hepatitis C Support Group, Mid-Peninsula Parents of Multiples Support Group, Smoking Cessation Program, Food Addicts in Recovery Anonymous, Pacific Chapter of the Neuropathy

Association, Pain Management Apprenticeship Support Group, American Cancer Society's Look Good… Feel Better Program, Pathways Grief Support Group, Nursing Mothers Counsel, LaLeche League, Hope House, Osteoporosis Support Group, Nursing and Rehab at Home, Bay Area Food Allergy Support Group and Meniere's Disease Support Group. The Health & Wellness Center's free meeting space served 3,210 community members this past year.

A crucial service provided by the Health & Wellness Center nurtures healthy families by offering breastfeeding support for new parents. The Community Lactation Services Team is made up of six international board certified lactation consultants who are also registered nurses. They staff a community advice line called the Lactation "Calm Line", which responds to thousands of calls each year. Community Lactation Services provided 2,928 individuals with more than $218,136 in breastfeeding support services. Lactation staff also facilitate the New Parents Support Group offered at the Health & Wellness Center. This past year 1,023 new parents participated in this free group that provides information and emotional support after the birth of a baby. The parents refer to this as "their village", which impacts their lives beyond the walls of Sequoia Hospital's Health & Wellness Center.

Sequoia Hospital recognizes the importance of offering hands-on training opportunities for our future health professionals and dedicates a significant amount of staff time for this purpose. During FY 2014, Sequoia staff mentored students in the following areas: central supply, clinical chaplaincy, wound care, lab science, phlebotomy, paramedic, pharmacy, physical therapy, physician's assistants, radiation oncology, radiology, health & wellness, case management and respiratory therapy. In total, more than 17,634 hours valued at $1,841,431 were dedicated to the direct training of 137 individuals across these health professions.

These activities are just a few of the ongoing projects that bring considerable value to our local community, as they further Sequoia's commitment to Community Benefit. FY 2015 promises to offer more opportunities to explore programming that aligns with Sequoia's priority areas.

These key programs are continuously monitored for performance and quality with ongoing improvements made to facilitate their success. Sequoia Hospital's Community Advisory Committee (CAC), Executive Leadership, the Community Board and Dignity Health receive quarterly updates on program performance and news.

The following pages include program digests for key programs that address Initiatives listed above:

- Child/Youth Healthy Development
- Healthy Aging in Place
- Dignity Health Sequoia Hospital Community Grants Program
- Chronic Disease Prevention and Management

PROGRAM DIGEST

Child/Youth Healthy Development	
Hospital CB Priority Areas	X Chronic Disease Prevention & Management ❑ Healthy Aging in Place X Child/Youth Healthy Development X Community Building
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention ❑ Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	• According to the 2008 Community Needs Assessment: "Excess weight and inactivity during childhood leads to higher risk of cardiovascular disease, type 2 diabetes, hypertension, stroke, certain types of cancer, as well as mental, emotional, and social stress later in life." • Key Finding 2011: Our children are not doing much better than adults in exhibiting healthy behaviors. This will severely impact their future health. • Research draws a direct relationship between youth development, or assets, and high-risk behavior. The more assets a young person has, the less likely he or she is to engage in high-risk activities. By making youth development a priority and offering young people opportunities to have useful roles in the community, we will help them build and strengthen their assets. This, in turn, will have a positive impact on their health and well-being.
Program Description	Sequoia Hospital demonstrates concern for the future health of our community by initiating and supporting Child/Youth Healthy Development programs. Key areas address a continuum of expectant and new parents, elementary and high school youth and their families. Make Time for Fitness (MTF) encourages healthy eating, physical activity, anti-bullying and avoidance of tobacco among elementary school students. Sequoia Hospital implements MTF in partnership with the Redwood City School District (RCSD) and dedicated Wellness Committee partners. Each year the program culminates in the Make Time for Fitness Day at Red Morton Park in Redwood City—a fun and educational fieldtrip for all fourth grade students in the district. Fourteen years ago one-mile walking courses were installed by Sequoia at every elementary school in Redwood City. The courses are utilized for Physical Education during school hours, are open for before- and after-school community programs and are used by neighborhood families and older adults during evenings and on weekends. The RCSD has consistently maintained these since their installation. Sequoia Hospital contributes to the health of high school youth, as well as parents and teachers, by serving on the SUHSD Wellness Advisory Committee and collaborating on programs which match our shared goals. These programs include contributing to a Wellness Newsletter for SUHSD staff, planning and funding a pilot program for Impact Testing for concussions, participating in CPR Training for all SUHSD freshmen students and providing leadership training for high school students to serve as role models and lead 4th grade students in the MTF program.
FY 2014	
Goal 2014	Empower school-aged children and their families in Redwood City and neighboring communities in the SUHSD to recognize and adopt behaviors for lifelong good health.

2014 Objective Measure/Indicator of Success	• Sequoia Hospital staff will lead the planning and implementation of Make Time for Fitness Program and annual MTF in Red Morton Park Fieldtrip for RCSD 4th grade students in May 2014. Written program evaluations will be requested from teachers, volunteers and students immediately following the event. Results will be reported to planning committee members. • We will track our contributions to requests from the RCSD and SUHSD for educational programs and support of events utilizing Sequoia Hospital's competencies and resources, as well as linkages to community based programs and assets.
Baseline	There is strong support of the RCSD and SUHSD Wellness efforts from community partners. The Sequoia Healthcare District has supported each district to develop the Healthy Schools Initiative model. RCSD and SUHSD now have wellness coordinators in place who provide strategic planning and support for implementation of programs. This structure promises to be an asset for supporting Sequoia Hospital's interest in impacting the health and future of children and families in these school districts.
Implementation Strategy for Achieving Goal	• The director of Health & Wellness will serve on Wellness Committees in SUHSD, RCSD, and San Carlos. This will promote identification of areas which utilize Sequoia Hospital competencies and resources and align with the strategic plans of both the wellness coordinators/committees and Sequoia Hospital for 2013-2014. • We will utilize our excellent community partnerships to plan and implement the Make Time for Fitness program for RCSD 4th grade students. The MTF workbook will be reviewed by Wellness Committee members. The Tobacco Education Coalition introduced concern for the increased availability and use of electronic cigarettes in our community. They will prepare fact sheets for use by teachers and parents. We will identify student groups at three SUHSD schools to receive training to participate in the interactive activity stations at the annual MTF fieldtrip. • We will plan a School Kick-off Assembly for Clifford School with a SF Giant Player and Spanish Radio Announcer in September 2013. • Sequoia staff will participate in CPR training for 9th grade students in SUHSD. • The Impact Test for concussions will be evaluated by the SUHSD Wellness Coordinator and Sequoia Hospital representative. A pilot program within the SUHSD will be considered for January 2014.
Results 2014	• In September 2013, a SF Giants Player and Spanish Radio Announcer were engaged by Sequoia Hospital to provide a Back to School Program on teamwork and leadership for 5-8th grade students at Clifford School. A Water First message was included. • In September 2013, Sequoia Hospital was invited to present the Make Time for Fitness Program as a best practice at the annual BanPac Conference. Our collaborative work with community organizations was honored as a Champion for Change. The MTF Program is being considered for replication in other Bay Area school districts. • Sequoia staff served on a committee advising community-based interventions to address pediatric obesity and consumption of sugar-sweetened beverages in childcare and school settings. This is led by a UCSF researcher and pediatrician. Her work was recognized by First Lady Michelle Obama at the White House this summer. In January 2014 a "Drink More Water" song and video (English and Spanish) that the committee consulted on was released. This is one element of a multi-faceted intervention focusing on encouraging healthy beverage intake among 2-5-year-old children through child care facilities. This song was presented live for children at the Sequoia Hospital Family Day in May 2014. • The annual Make Time for Fitness in Red Morton Park was planned and

	implemented for 1,065 RCSD 4th grade students on May 15, 2014. Written program evaluations were submitted by 19 volunteers and 50% of teachers representing 20 classes from 13 of 14 schools. A post-quiz questionnaire was completed by 45% of students representing 93% of schools that attended. Results will be reported to the 2015 Make Time for Fitness planning committees to be convened in Fall 2014. • Sequoia Hospital participated in San Carlos School District Abilities Awareness Week by loaning a wheel chair to provide students with a "hands on" use experience and by donating a wheel chair to Arundel School to be used to transport students who are injured or ill on their multi-tiered campus. • Freshman CPR Training SUHSD: In conjunction with Sequoia Healthcare District and local firefighters, Sequoia Hospital staff assisted in CPR training for >1500 freshmen. An additional 60 students enrolled in special needs programs were trained. Students received vital life-saving information in a learning environment that promoted team work, self-esteem and a sense of community responsibility. • "Impact Test" concussion education and baseline testing pilot at Woodside High School: Sequoia Hospital staff collaborated with SUHSD wellness coordinator, Woodside principal, a community pediatrician, and boy's lacrosse team coach. In January 2014, conducted parent/student education and obtained baseline neurocognitive data on 25 athletes to aid in the evaluation and treatment plan for concussions. In Spring 2014, Sequoia community nurse created and staffed a concussion education booth at site-based health fairs that reached over 2500 students. Sequoia Hospital funded the Impact Test computerized program. • SUHSD Leadership at MTF May 2014: Fifty teen volunteers from Carlmont High School SOS, Sequoia High School Health Career Academy and Woodside High School SOS and Safe School Ambassador students were trained and led activity stations and served as role models for over 1,000 RCSD 4th grade students. • Sequoia staff served on RCSD Water First Campaign, including doing student surveys regarding water drinking habits and availability at their school site.
Hospital's Contribution / Program Expense	Activities with RCSD: $6,203 Make Time for Fitness/Red Morton Park: $37,982 Childhood Obesity Task Force: $268 Wellness Policy Committee: $716 **Total: $45,169**
FY 2015	
Goal 2015	Empower school-aged children and their families in Redwood City and neighboring communities in the SUHSD to recognize and adopt behaviors for lifelong good health.
2015 Objective Measure/Indicator of Success	• Sequoia Hospital staff will lead the planning and implementation of Make Time for Fitness Program and annual MTF in Red Morton Park Fieldtrip for RCSD 4th grade students in May 2015. • Students will be given a pre-test before introduction of the Make Time for Fitness workbook in the classrooms in April 2015. A post-test will be given after the MTF Event in May 2015. • Written program evaluations will be requested from teachers, volunteers and committee members immediately following the MTF fieldtrip. Results will be reported to planning committee members and will be utilized for future planning. • We will track our contributions to requests from schools for educational programs and support of events utilizing Sequoia Hospital's competencies and resources, as well as linkages to community based programs and assets.
Baseline	There is strong support of the RCSD and SUHSD Wellness efforts from community

	partners. The Sequoia Healthcare District continues to support each district to develop the Healthy Schools Initiative model. RCSD and SUHSD now have Wellness Coordinators in place who provide strategic planning and support for implementation of programs. This structure is an asset for supporting Sequoia Hospital's interest in impacting the health and future of children and families In these school districts.
Implementation Strategy for Achieving Goal	• The director of Sequoia Hospital Health & Wellness will serve on RCSD, SUHSD and San Carlos wellness committees. • A SF Giant Player Assembly for Henry Ford School (1-5th grades) will be planned for August 2014. The theme will be teamwork, nutrition, physical activity and Drink Water First. • CPR Training for 9th Grade Students will begin in August 2014. • Impact Testing will be expanded to Carlmont High School Cheerleaders and Football Team and Woodside High School Water Polo players in Fall 2014. Procedures for care following a concussion will be finalized utilizing community pediatric care physicians and urgent care sites. Sequoia Hospital will pay for 300 Impact Tests and 50 post-concussion tests for the SUHSD. • Concussion education outreach to students, families, coaches, and the community will continue during the 2014-2015 school year. • A Make Time for Fitness planning and implementation committee for 2015 will be convened by the director of Health & Wellness in Fall 2014. Members will include community partners, volunteers, members of the RCSD wellness committee and SUHSD leadership. • Make Time for Fitness student leadership training is a strategic goal of the SUHSD Wellness Advisory Committee. Plans include expanding the program to include students from Redwood and Menlo Atherton High Schools, in addition to returning to schools that participated in 2013 and 2014. • Cardiac Screening Program in SUHSD: a district-wide cardiac screening program to identify cardiac abnormalities, with the goal of identifying disease and allowing for proactive intervention and follow-up is being considered by a collaboration with SUHSD, Sequoia Healthcare District, the NFL Alumni Association and Sequoia Hospital. Launch date: March 2015.
Community Benefit Category	A1: Community Health Education F7: Community Building Activities

Healthy Aging in Place	
Hospital CB Priority Areas	❑ Chronic Disease Prevention & Management X Healthy Aging in Place ❑ Child/Youth Healthy Development ❑ Community Building
Program Emphasis	X Disproportionate Unmet Health-Related Needs ❑ Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	According to the 2013 Community Health Needs Assessment: **Population Growth & Makeup** 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. **Low-Income Seniors** Many area seniors live on low incomes. Of the households surveyed in 2013, 16.0% of seniors reported household incomes below 200% of the Federal poverty level. **Seniors Living Alone** In the 2013 San Mateo County Health & Quality of Life Survey, 36.6% of responding seniors (aged 65 and older) lived alone. (North Fair Oaks, 94063, 40.3%) **Chronic Conditions** San Mateo County seniors (aged 65 and older) experience much higher prevalence of many chronic conditions than found among adults younger than 65. We have seen a statistically significant trend in higher prevalence of diabetes, asthma and chronic lung disease among San Mateo County seniors since 1998. **Mental Health** 11.5% of seniors have someone for emotional support "little" or "none" of the time. 32.5% residents of North Fair Oaks (94063) have sought professional help for a mental issue. **Activity Limitations** 4.6% of seniors report some type of impairment, which requires help with their personal needs, and 9.2% (North Fair Oaks, 94063, 9.5%) report an activity limitation requiring help with their routine needs. Seniors report an average of 3.0 days in the preceding month when pain has made it difficult for them to do their usual activities, such as self care, work or recreation (74.3% reported no days).
Program Description	The Sequoia Community Care program aims to provide effective approaches to better support "*at-risk*" community members to understand and manage their health conditions, access the vast array of community services that can help prevent an expensive health crisis (e.g. hospitalization and/or institutionalized care), and transition safely home when hospitalization does occur. As designed, Sequoia Community Care (SCC) is a referral-based program with "at risk" candidates identified by a transitional care nurse, case managers and social workers at Sequoia Hospital utilizing the Risk for Readmission tool that is embedded in the Adult Admission Form. Our goal is to provide a personalized connection with these individuals to assist them in learning how to make the most of their own resources and those resources available within our community so their health is maintained and they don't relapse for preventable reasons.

	Resources include:
	• hospital bed-side visit by a Transitional Care Nurse (TCN) to help coordinate services for a successful transition
	• home visit by the TCN to provide individualized transitional care coaching to help clients stabilize at home, such as
	  o help with understanding medications
	  o tips to communicate effectively with their health care team
	  o establishing a personal health record for better continuity of care
	  o learning "Red Flag" signs and symptoms to report to their physician
	• home-delivered nutritious meals and wellness checks every weekday for four weeks*
	• social services to help older adults keep connected to the community and the resources they need to live healthy, fulfilling lives
	• transportation for older adults to medical and allied health appointments*
	• home care services to help with activities of daily living*
	• adult day services for memory impaired individuals*
	• educational workshops to support caregivers
	• chaplain service for those who have experienced a loss, have a need for Advance Directive consult and/or a desire to connect with a faith community
	*upon referral
	
	For the purposes of this program "*at risk*" individuals are those who are age 50 and above, live in Atherton, Belmont, Menlo Park, Portola Valley, Redwood City, San Carlos, Southern San Mateo or Woodside AND meet at least one of the following:
	• Live at home with limited or no community support
	• Require assistance with medication management
	• Require assistance with activities of daily living
	• Have three or more chronic conditions
	• Take six or more medications
	• Have had multiple hospital admissions
	
	SCC program design incorporates the following foundational features:
	• Early identification of "*at risk*" community residents (intervene before a health crisis)
	• Centralized intake, assessment, and quality oversight
	• Medical and social integration through acute, post-acute phase of recovery
	• A rich history of strong collaborative relationships with multiple community-based non-profit organizations that provide in home social, medical, nutritional support to the vulnerable older adults of our community post discharge and beyond.
	• Expansion of service offerings
	• Multiple access points allowing referrals from physicians
	• Electronic connectivity among community service providers and with the patient's physician
	• Community outreach

FY 2014	
Goal FY 2014	SCC is intended to promote the successful recuperation of older adults after they return home from the hospital through a coordinated, collaborative effort between Sequoia Hospital social workers/discharge planners and community agencies with unique capacities to deliver the SCC strategy. SCC will be expanded to provide more referrals for emergency room patients and from local physician's offices and skilled nursing facilities.
2014 Objective Measure/Indicator of Success	• SCC client re-admission rates within 30 days of initial hospital discharge will be tracked and will remain below 10%. • Formal client evaluations of SCC services will be conducted and reported in FY 2014. Goal will be a 50% return. • SCC collaborative partners will meet monthly to share successes and challenges and to make adjustments to the program. • Dignity Health Sequoia Hospital Community Grants Program will provide funding

	support for SCC. Grants will be awarded in January 2014. • The CAC recommended that the SCC collaborate with CBO's that addressed memory care and care giving and invited them to apply for the Dignity Health Sequoia Hospital Community Grants Program. • SCC referrals and number served will be increased to 125 clients. • The SCC program will be introduced to local physician offices, Skilled Nursing facilities and appropriate referrals will be accepted.
Baseline	There are no transitional care programs or formal collaborative efforts to promote cross referrals between community agencies serving vulnerable older adults in our community.
Implementation Strategy for Achieving Goal	A three-year pilot project is underway during which we will establish SCC outcome data and sustainability funding. Sequoia Hospital Health & Wellness Center has been launched as the "*HUB*" through which the program components of SCC are being organized. This includes program leadership and accountability; standardization and consistency around intake, referral, and care plan development; delivery of services; quality control; outcome tracking; and the management of electronic connectivity among service providers. Several essential components must be addressed to ensure program success. • An information technology (IT) solution must be identified, purchased, and implemented to allow for efficient communication and organization among community agency providers as well as crucial communication with home health agencies, skilled nursing facilities and primary care physicians. A concerted effort will be made to identify clients of Ravenswood and Samaritan House to better coordinate care with the client's health home base. A consulting firm has been hired to identify an appropriate technology vendor, and technology funding sources are being explored. • A full-time community-based case manager must be hired to assume leadership and accountability for coordinating the services for the beneficiaries that are enrolled in the Sequoia Community Care program. Currently this role is being filled on a part-time basis by staff of the Health & Wellness Department. • Promote inter-department communication. The Health & Wellness Center community health supervisor nurse will attend monthly Sequoia Hospital case management's multi-disciplinary meetings. The director of Sequoia Hospital case management will serve on the IT vendor identification committee team and members of the SCC will serve on the readmission task force. • The in-patient discharge summary will identify patients at risk for falls and the SCC will provide Fall Prevention education and class information following discharge. • Explore the use of a depression screening so that we will be able to make appropriate and safe referrals and identify opportunities for partnership. • Sequoia Hospital and the Sequoia Hospital Foundation are actively seeking other funding sources to assure that the program is fully funded and operational during the pilot period. Thorough tracking and documentation ensure sustained funding for the Sequoia Community Care program following the pilot period.
Result FY 2014	• SCC client re-admission rates: 30 days of initial hospitalization 4% 90 days of initial hospitalization 1% • SCC client re-admission rate (not including those who had 2 or more re-admissions) 30 days of initial hospitalization 2% 90 days of initial hospitalization 0%

	• A formal client evaluation of SCC services was revised by SCC partners and Applied Survey Research. Surveys were completed by 61% of participants. • SCC collaborative partners held monthly meetings to share successes and challenges and to make adjustments to the program. • Dignity Health Sequoia Hospital Community Grants Program provided funding to the SCC community partners. Grants were awarded in February 2014. • A Memory Care and Caregiving Collaborative of four community based organizations were funded and have joined the SCC partners. • Depression screening tool was added to initial in-home assessment but then retracted. Through the Depression Screening Tool pilot, we learned that there are not enough referral sources readily available for the depression program. The transitional care nurse provides the number for "The Friendship Line", an accredited crisis intervention program for the elderly, available through the Institute on Aging (if depression/loneliness are identified needs). • IT solution was identified but not initiated. Interim solution was developed by the physician consultant and collaborative partner in the program, in Microsoft Data Access for statistic collection. Mobile MD was utilized as a secure messaging communication tool between HUB, hospital, and community-based partners. • Awarded Gordon and Betty Moore Foundation Grant for $350,000. TCN hired and Coleman Training provided for social worker, transitional care nurse, community nurse and spiritual care staff. • Maintained patient connection to medical home by identifying Ravenswood and Health Plan of San Mateo patients and informing these medical homes of patient admission. • SCC referrals and number served increased to 162 clients. • Collaborated with Lifeline, a medical alert system, to offer promotional free set-up and free 60 days of service for SCC clients. • As a pilot, the San Mateo Medical Center Discounted Health Care Group was eligible to be referred by SMMC to the SCC Program.
Hospital's Contribution / Program Expense	Expenses: $187,997 Offsetting grant dollars: $167,292 **Total: $19,705**
FY 2015	
Goal 2015	SCC is intended to promote the successful recuperation of older adults after they return home from the hospital through a coordinated, collaborative effort between Sequoia Hospital social workers/discharge planners and community agencies with unique capacities to deliver the SCC strategy. SCC will be expanded to include more referrals from the emergency room and local skilled nursing facilities.
2015 Objective Measure/Indicator of Success	• The transitional care program will reduce the 30-day and 90-day all cause readmission rates for eligible Sequoia Hospital patients by 30% and 15% respectively compared to a 2013 baseline. • Formal client evaluations of SCC services will be conducted and reported in FY 2015. Goal will be a 25% return. • SCC collaborative partners will meet six times during FY 2015 to share successes and challenges and to make adjustments to the program. • Dignity Health Sequoia Hospital Community Grants Program will provide funding

	support for SCC. Grants will be awarded in January 2015. • SCC referrals and number served will be increased to 200 clients. • The SCC program will be introduced to local skilled nursing facilities and appropriate referrals will be accepted. • SCC will track referrals made to Matter of Balance Classes for fall prevention. • Work in collaboration with the Sequoia Quality Care Network (SQCN) to transition eligible patients into their care management program after the 30 day program.
Baseline	Sequoia Hospital Readmission Rate for patients discharged over 50 years of age to home without skilled Services. FY13 30-day 13.33%; 90-day 8.09%

Implementation Strategy for Achieving Goal	Essential components must be addressed to ensure program success. • An information technology (IT) solution must be identified, purchased, and implemented to allow for efficient communication and organization among community agency providers as well as crucial communication with home health agencies, skilled nursing facilities and primary care physicians. A concerted effort will be made to identify clients of Ravenswood and Samaritan House in order to better coordinate care with the client's health home base. • Promote inter-department communication. The Health & Wellness Center transitional care nurse will attend daily Sequoia Hospital case management's multi-disciplinary meetings. • The director of Sequoia Hospital Case management and SCC team members will serve on the Readmission Task Force at Sequoia Hospital and on the San Mateo County Readmission Task Force. • The in-patient discharge summary will identify patients at risk for falls and the SCC will provide fall prevention education and class information following discharge. Utilize Matter of Balance evidence based programs in the community for referrals. • Congestive Heart Failure Disease management course to be offered to eligible patients • Work with case management, Sequoia Quality Care Network and local skilled nursing facilities to establish new workflows • SCC Partners Retreat in August 2014 to discuss communication and collaboration. Plan meeting format for FY 2015. • In order to address the needs of the most vulnerable in our program, collaborate with Adult Protective Services to provide workshops to educate our staff and the staff of our community partners. • Further develop the collaboration with San Mateo Medical Center to determine how to best utilize the organizational resources of the program's clinical partners to best serve patients discharged from SMMC and Sequoia Hospital. There is also a need to establish a sustainability plan for the program in order to ensure we can all continue to serve our at-risk patients after discharge in the absence of outside funding • Establish cross-referral communication with transitional care personnel at Health Plan of San Mateo for the increasing patient population at Sequoia Hospital.
Community Benefit Category	A3: Health Care Support Services

Dignity Health Sequoia Hospital Community Grants Program	
Hospital CB Priority Areas	X Chronic Disease Prevention & Management X Healthy Aging in Place ❑ Child/Youth Healthy Development X Community Building
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	Grant funds to non-profit organizations will be used to provide services addressing the health priorities established by Sequoia Hospital and based on the results of the latest SMC CHNA. "We live in a geographic area that can be thought of as a 'magnet place' that has a self-reinforcing economic and social ecology that concentrates and multiplies innovation, creativity, wealth and health." 2013 SMC CHNA Key Finding.
Program Description	Upon the recommendation of the Local Grant Review Committee of the CAC, the Dignity Health Sequoia Hospital Community Grant Program focused on the concept of collaboration with the goal of developing strategic partnerships between community-based organizations and Sequoia Hospital. Resources will be leveraged and address priority health issues in creative ways that have a direct, positive and lasting impact on the health of identified individuals in our community. The 2014 Dignity Health Community Grant Program has made this collaboration a criteria for funding.
FY 2014	
Goal FY 2014	The Grant Program focuses on collaboration between three to four community-based organizations that share in knowledge, learning and building consensus to reach an identical objective.
2014 Objective Measure/Indicator of Success	• One agency will be identified and serve as a Fiscal Agent for the collaboration. • Each partner will have a clearly defined role. • The collaboration will measure outcomes collectively. • The partners will need to carefully budget and allocate funds among their group according to cost and level of services provided. • Proposals must identify the type of change expected and how and over what time period progress will be measured. • Proposals must include a sustainability plan for the project after funding is completed.
Baseline	The current economy continues to provide multiple challenges for non-profit agencies in our service area. At a time when more individuals are requiring and seeking services, budgets are being reduced at unprecedented rates. Teams that work collaboratively can obtain greater resources, recognition and reward when facing competition for finite resources.
Intervention Strategy for Achieving Goal	The CAC and current SCC partners recommended adding a memory care and caregiving service line. Current SCC partners were invited to submit a collaborative proposal for ongoing support of the SCC program.
Result FY 2014	Funding was received by Peninsula Family Service as fiscal agent for a collaborative in support of the SCC Program. Partners and roles are: • Peninsula Family Service (social services) • Peninsula Volunteers, Inc. (meals) • Jewish Family and Children's Services (in-home services) • Samaritan House Redwood City Free Clinic (coaching) • Peninsula Jewish Community Center - Get Up & Go (transportation) Funding for a Memory Care and Caregiving Collaborative was received by

	Peninsula Volunteers, Inc. as fiscal agent. Partners and roles are: • Peninsula Volunteers, Inc. - Rosener House • Catholic Charities CYO- San Carlos Adult Day Center • Family Caregiver Alliance-Memory Care and Care Giving • Alzheimer's Association-Dementia and Care Giving Dignity Health Sequoia Hospital received prestigious recognition for service in the community and promoting collaborations and partnerships. In November 2013 The Association of Fundraising Professionals Silicon Valley Chapter (AFP) honored Dignity Health Sequoia Hospital with an award for Outstanding Corporate Grant Maker with more than 300 employees. We were nominated by our community partners: Peninsula Family Service, Peninsula Volunteers, Inc. and Samaritan House. In June 2014, representing Dignity Health, the director of Health & Wellness received the Jefferson Champion Award in Washington D.C. for outstanding community service and promoting community collaboration.
Hospital's Contribution / Program Expense	**Total: $110,000**
FY 2015	
Goal 2015	Dignity Health is requiring formal collaborative partnerships for the 2015 funding year. The Grant Program remains focused on collaboration where three to four community based organizations sharing knowledge, learning and building consensus to reach an identical a common objective.
2015 Objective Measure/Indicator of Success	• One agency will be identified and serve as a fiscal agent for the collaboration. • Each partner will have a clearly defined role. • The collaboration will measure outcomes collectively. • The partners will need to carefully budget and allocate funds among their group according to cost and level of services provided. • Proposals will identify the type of change expected and how and over what time period progress will be measured. • Proposals will include a sustainability plan for the project after funding is completed.
Baseline	The current economy continues to provide multiple challenges for non-profit agencies in our service area. At a time when more individuals require and seek services, budgets are being reduced at unprecedented rates. Teams that work collaboratively can obtain greater resources, recognition and reward when facing competition for finite resources.
Intervention Strategy for Achieving Goal	• Members of the Sequoia Hospital's Community Advisory Committee will serve on a Local Grant Review Committee for the 2015 Community Grants Program. • Criteria for grants will follow Dignity Health guidelines and meet Sequoia Hospital's strategic plan and community benefit initiatives. • The SCC program partners suggested that organizations providing transportation and deep house cleaning assistance be invited to submit Letters of Intent as part of a collaborative. • For-profit organizations can be included as collaborative partners in FY 2015 proposals. • To further promote the concept of collaboration for grant funding in our community, Sequoia's grant representative will advise organizations before they apply and share committee concerns and comments if they are not invited to receive funding. • $106,000 will be awarded to approved collaboratives in January 2015.
Community Benefit Category	E2: Grants

Chronic Disease Prevention & Management	
Hospital CB Priority Areas	X Chronic Disease Prevention & Management ❑ Healthy Aging in Place ❑ Child/Youth Healthy Development ❑ Community Building
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment	According to the 2013 Community Needs Assessment: 85.4% of the San Mateo County (SMC) adults exhibit at least one cardiovascular risk factor (i.e. smoking, no regular physical activity, high blood pressure, high cholesterol, or being overweight). High blood pressure is known as the silent killer and remains a major risk factor for coronary heart disease, stroke, and heart failure. High blood pressure is most prevalent in San Mateo County among seniors (58.7% among those aged 65 and older), adults living below the 200% threshold (32.9%), whites (31.4%), and blacks (38.9%). A total of 30.4% of San Mateo County adults say they have been told more than once by a health care professional that they have high blood cholesterol. High blood cholesterol affects more than 4 in 10 residents aged 40+ in San Mateo County. Most San Mateo County respondents (53.9%) do not participate in regular, vigorous physical activity. The prevalence of inactivity in San Mateo County is notably higher among: women (58.5%); persons aged 65 and older (73.4%); persons with a high school education or less (60.9%) and those households with annual incomes <400% poverty (>62%). Based on reported heights and weights, 55.4% of San Mateo County respondents are overweight. men (62.8%); women (47.9%); ages 40-64 (62.1%); Whites (56.4%); Hispanics (61.5%). Additionally, 21.7% of San Mateo County adults were found to be obese, having a body mass index of 30 or higher. The obesity prevalence increases with age and decreases with education and income levels. The prevalence is highest among Blacks and Hispanics. The rate of diabetes in San Mateo County is up 2.5 times over the past 10 years. The greatest increases have been in whites, females and in those over 65 years of age. The 2013 CHNA finds 10% of the adult population has diabetes, which represents approximately 57,130 adults. The rate of diabetes in southern San Mateo County is 9.3%. Falls are a key issue leading to hospitalization, loss of independence, and death among seniors. The population of San Mateo County residents who are 65 years of age and older will increase by 72% by 2030 and over 85 year old age group will increase by 2.5 times the current numbers. This oldest group has a 2 fold chance of falling due to frail conditions. According to 2012 OSHPD data, 200 individuals over age 65 years were transported to Sequoia Hospital for a fall. This number includes both those treated and released and those admitted. There were 13 deaths reported due to falls.
Program Description	The Adult Screening, Health Education and Vaccine Program is conducted monthly at eight sites in the community and at the Sequoia Hospital Health & Wellness Center in downtown Redwood City. Community locations are: Mid-Peninsula Housing-Menlo Park, Twin Pines Adult Activity Center-Belmont; San Carlos Adult Activity Center; Veteran's Memorial Adult Center and Vet's Adaptive PE Program –Redwood City; Little House-Menlo Park; Fair Oaks Adult Activity Center-Redwood City and the Belmont Library. Our focus is on meeting the needs of high-risk populations by collaborating with community partners at convenient sites where individuals live, gather and are comfortable.

	Services include free screenings for blood pressure and diabetes, monitoring screening results, one-on-one education, referrals to physicians for abnormal results, providing health education lectures and health articles for newsletters. Vaccines include seasonal flu and pneumococcal vaccine clinics and immunizations for Tdap and Shingles. . Sequoia Hospital's Fall Prevention Program for the community includes a free, three-week course at the Health & Wellness Center. The course curriculum is based on best practices in fall prevention and addresses the many factors affecting falls. Each course is taught by trained health professionals and includes simple exercise to improve strength and balance. Sequoia Hospital and Stanford Health Care are collaborating to provide evidence-based Matter of Balance classes in English and Spanish to underserved populations in southern San Mateo county. Sequoia actively participates in the San Mateo County Fall Prevention Task Force. We collaborate with more than 50 community organizations to create and disseminate fall prevention resources. The Live Well with Diabetes (LWD) program provides culturally competent nutrition, physical activity and diabetes management education in free three-week sessions. The majority of classes are taught in Spanish by trained Diabetes Health Promoters (DHP's) who were recruited through Cañada College's Promoter Education and Employment Project (PEEP). LWD is a collaboration of Sequoia Hospital, Peninsula Family Service, Samaritan House and Cañada College.
FY 2014	
Goal 2014	To contribute to the cardiovascular health of identified target populations in the community to enable individuals to manage risk factors and improve their overall well-being. To decrease the rate of falls among older adults in the community. To help prevent and reduce the incidence of diabetes and prevent complications of diabetes among people living in the underserved Latino community of southern San Mateo County.
2014 Objective Measure/Indicator of Success	• Provide monthly blood pressure screenings and education at seven community centers for 820 participants. Expand service to employees of city of Belmont, as part of their newly adopted Employee Wellness Program. • Provide quarterly diabetes screenings and education at five adult community centers. Conduct quarterly LWD support group at Fair Oaks Adult Activity Center. • Provide low-cost health screenings and classes to a minimum of 60 individuals at the Health & Wellness Center. • Provide low-cost immunizations for flu, pneumococcal, shingles and Tdap for 250 adults and 150 youth. • Conduct a monthly "Maturing Gracefully" health lecture series at the Belmont Library in partnership with Friends of the Belmont Library and maintain an attendance of 35-40 participants/month. • Sequoia Hospital's Diabetes Treatment Center staff will provide continuing education for Live Well with Diabetes health promoters (DHP). • Each DHP will successfully complete the American Association of Diabetes Educators self-paced, 6 module online program. • Conduct six Matter of Balance courses at sites in southern SMCo in collaboration with Stanford Health Care. • Support the SMCo Fall Prevention Task Force with in-kind and financial resources to provide advocacy for community health improvement.

Baseline	Monthly screenings give individuals a way to monitor their blood pressure and glucose to promote healthy aging in place. Conducting programs at centers for older adults, where blood pressure and diabetes screening services are not offered, provides access for a vulnerable population. Falls are a key issue leading to hospitalization, loss of independence and death among seniors; more resources should be directed toward this preventable condition. 2011 CHNA.
Implementation Strategy for Achieving Goal	• Meet with each adult community center director to evaluate screening program, review center's annual screening results and discuss plans to collaborate and enhance services provided by Sequoia Hospital Health & Wellness Center. • Offer low or no cost screenings for high cholesterol, hypertension and diabetes, as well as counseling and routine monitoring at Sequoia Hospital Health & Wellness Center and at senior/community center sites. • Health & Wellness Community Health Supervisor will write and regularly submit "A Conversation with a Community Nurse" health article for center newsletters. Topics will address identified health education needs of population at each center. • Conduct Flu and Pneumococcal Vaccine Clinics for the San Mateo County Health System at Sequoia Hospital Health & Wellness Center beginning in October 2013. • Provide Tdap and Shingles vaccinations for adults at the Sequoia Hospital Health & Wellness Center on bimonthly screening days. • Provide stroke awareness information and medication cards and monitor their use at monthly blood pressure screenings. Submit an article on stroke awareness for center/community newsletters. Distribute stroke alert cards at train stations as part of a County-wide stroke awareness program. • Explore the use of a depression screening so that we would be able to make appropriate and safe referrals and identify opportunities for partnership. • Collaborate with Belmont Park and Recreation Department to support Tai Chi classes at Twin Pines Adult Center that incorporate fall prevention education.
Result FY 2014	Monthly blood pressure screenings were provided at seven centers in the community. Results of 786 Blood Pressure Screenings: • 213 older adults (27%) were hypertensive, a 5% increase from 2013 • 144 older adults (18%) were referred to a physician, a 7% increase from last year • 261 older adults (33%) were counseled by an RN on cardiovascular risk reduction behaviors, an 8% increase from last year. • 10 (1.2%) had irregular or low heart rates and were advised to report to MD Quarterly Diabetes Screenings: • Twin Pines Adult Community Center: 49 screened; 24 (48.9%) elevated • Fair Oaks Adult Activity Center: 35 screened; 12 (34.2%) elevated • Veteran's Adaptive PE: 60 Screened; 10 (16%) elevated • Mid-Peninsula Housing: 10 Screened; 2 (20%) elevated The participants at Fair Oaks are 90% Spanish speaking. The key to participation and effective counseling at Fair Oaks is attributed to having a Wellness Navigator provided by their center for Spanish interpretation. • 59 participants representing seven centers completed evaluations of blood pressure screenings in FY 2014. Comments regarding monthly screenings included: "appreciated convenience, easy, free, professional, efficient, and good for the uninsured." Responses to why screenings are important included "to stay alive, no one wants a stroke, awareness, blood pressure reminds us of other problems going on, significant to stroke, heart attack, diabetes, feel safer and gives peace of mind

	knowing my blood pressure." • 93.2% reported that they share the results of screenings with their MDs. The Sequoia Hospital Health & Wellness Center provided: Low-cost health screenings for 82 adults County Flu Vaccine Clinic for 332 adults Adult Immunizations (Tdap, Pneumococcal, Flu, Shingles) for 55 adults • Sequoia Hospital Health & Wellness Center responded to the need for Tdap vaccinations for entering 7th graders to comply with the new state mandate. Offered 32 vaccinations to incoming 7th graders that had not been vaccinated. • Provided monthly educational health lectures for the Belmont Library "Maturing Gracefully" series. Topics included Coping with the Holidays, Advance Directives and POLST, Nutrition for Cardiovascular Health, Healthy Meal Planning, Fall Prevention, Osteoporosis, Sleep, Memory Disorders, and Diabetes. An average of 40-45 community members attended each month. • Results of Live Well with Diabetes Classes: During follow-up phone interviews with 80 students, conducted three months following the class, two participants reported being admitted to a hospital or a visit to an emergency department within ninety days of completing the class. • The Diabetes Health Promoters were provided with extensive refresher education opportunities and support from all of the collaborative partners. They each completed a Fundamentals of Diabetes Care: Certificate Program for Healthcare Technicians, an online self-study course offered by the American Association of Diabetes Educators. • Supported "Become Healthy thru Tai Chi" classes in Belmont that served 80 participants. Evaluations expressed how the class helped some to deal with vertigo, bursitis, surgeries, heart conditions, and old and new injuries in addition to fall prevention techniques.
Hospital's Contribution / Program Expense	Expenses: $31,224 Offsetting income: $2,065 **Total Community Net Benefit: $29,159**
FY 2015	
Goal FY 2015	To contribute to the cardiovascular health of identified target populations in the community to enable individuals to manage risk factors and improve their overall well-being. To decrease the rate of falls among older adults in the community. To help prevent and reduce the incidence of diabetes and prevent complications of diabetes among people living in the underserved Latino community of southern San Mateo County.
2015 Objective Measure/Indicator of Success	• 210 participants per quarter will participate in monthly blood pressure screenings and education at six community centers. • Quarterly diabetes screenings and education will be provided at three adult community centers. Quarterly LWD Support Groups will be led at the Fair Oaks Adult Activity Center in Spanish. • A minimum of 60 individuals will receive low-cost health screenings and classes at the Health & Wellness Center. • 125 adults per quarter will receive low-cost immunizations for flu, pneumococcal and Tdap. • Monthly attendance of 40-50 older adults will be maintained at the Maturing Gracefully lectures at the Belmont Library.

	• In May 2015, an annual satisfaction survey will be conducted at all screening sites in order to provide feedback on Sequoia Hospital screening programs from center directors and participants. • Live Well with Diabetes classes will be conducted in underserved areas. Calls will be made to participants three months following the class to report participant's sustaining behavior changes, avoiding hospital emergency department visits and hospital admissions for diabetes. • Fall Prevention: Sequoia Hospital will train five coaches to lead Matter of Balance classes. Classes will be conducted at sites in southern San Mateo County in collaboration with Stanford Health Care.
Baseline	Conducting LWD classes, Matter of Balance classes and monthly programs at centers for older adults, where screening services and classes are not offered, provides access for a vulnerable population.
Implementation Strategy for Achieving Goal	• Offer low or no cost screenings for high cholesterol, hypertension and diabetes, as well as counseling and routine monitoring at Sequoia Hospital Health & Wellness Center and at senior/community center sites. • Conduct Flu and Pneumococcal Vaccine Clinics for the San Mateo County Health System at Sequoia Hospital Health & Wellness Center beginning in October 2014. • Explore opportunities to collaborate with Health Plan of San Mateo to offer chronic disease management classes at the Wellness Center for their patient population. • Provide stroke awareness information and medication cards and monitor their use at monthly blood pressure screenings. • Utilize the competencies of Sequoia Hospital clinicians and experts from our community partners to educate community members through lectures, screenings, newsletters and one-on-one consultations. • Evaluate and consider discontinuing Sequoia Hospital's Fall Prevention Classes at Health & Wellness and focus on training Matter of Balance program coaches and conducting classes at community sites. • A Live Well with Diabetes class observation followed by consultation with each DHP will be made during FY 2015 to evaluate the revised LWD curriculum. LWD class pre-post tests and evaluations will be reviewed by a representative of the Diabetes Treatment Center. Feedback will be shared with the instructor.
Community Benefit Category	A1. Community Health Education A2: Community Based Clinical Services

This implementation strategy specifies community health needs that the Hospital has determined to meet in whole or in part and that are consistent with its mission. The Hospital reserves the right to amend this implementation strategy as circumstances warrant. For example, certain needs may become more pronounced and require enhancements to the described strategic initiatives. During the three years ending December 31, 2016, other organizations in the community may decide to address certain needs, indicating that the Hospital then should refocus its limited resources to best serve the community.

COMMUNITY BENEFIT AND ECONOMIC VALUE

In Fiscal Year 2014, Sequoia Hospital provided $46,759,453 in unsponsored care and programs for the benefit of our community. The following table offers a summary of the expenses and persons served by Sequoia's Community Benefit programs for this past fiscal year.

9/24/2014
240 Sequoia Hospital
Complete Summary - Classified Including Non Community Benefit
For period from 7/1/2013 through 6/30/2014

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Benefits for Vulnerable						
Financial Assistance	**1,090**	**787,990**	**0**	**787,990**	**0.4**	**0.3**
Medicaid	**7,203**	**13,659,085**	**4,672,447**	**8,986,638**	**4.1**	**3.8**
Community Services						
Community Benefit Operations	2	40,801	0	40,801	0.0	0.0
Community Health Improvement Services	572	233,371	167,292	66,079	0.0	0.0
Financial and In-Kind Contributions	2	177,471	0	177,471	0.1	0.1
Subsidized Health Services	3	13,740	0	13,740	0.0	0.0
Totals for Community Services	**579**	**465,383**	**167,292**	**298,091**	**0.1**	**0.1**
Totals for Vulnerable	**8,872**	**14,912,458**	**4,839,739**	**10,072,719**	**4.6**	**4.3**
Benefits for Broader Community						
Community Services						
Community Building Activities	50	115,592	0	115,592	0.1	0.0
Community Health Improvement Services	9,270	307,270	2,065	305,205	0.1	0.1
Financial and In-Kind Contributions	3,210	151,200	0	151,200	0.1	0.1
Health Professions Education	137	1,994,056	152,625	1,841,431	0.8	0.8
Totals for Community Services	**12,667**	**2,568,118**	**154,690**	**2,413,428**	**1.1**	**1.0**
Totals for Broader Community	**12,667**	**2,568,118**	**154,690**	**2,413,428**	**1.1**	**1.0**
Totals - Community Benefit	**21,539**	**17,480,576**	**4,994,429**	**12,486,147**	**5.7**	**5.3**
Medicare	**29,117**	**94,264,000**	**59,990,694**	**34,273,306**	**15.5**	**14.5**
Totals with Medicare	**50,656**	**111,744,576**	**64,985,123**	**46,759,453**	**21.2**	**19.8**
Totals	**50,656**	**111,744,576**	**64,985,123**	**46,759,453**	**21.2**	**19.8**

The above costs are actual costs calculated using cost account methodology.

TELLING THE STORY

To effectively tell the story of Sequoia Hospital's excellent Community Benefit work, a plan is in place for sharing this report as broadly as possible. Sequoia Hospital and the CAC plan to do the following in the coming months:

The 2013 Community Health Needs Assessment: Health & Quality of Life in San Mateo County is posted on the Sequoia Hospital website. Hard copies of the full assessment are available at the Administration Office at Sequoia Hospital and at Sequoia Hospital Health & Wellness Center at 749 Brewster Avenue, Redwood City, CA.

Hard copies of the Executive Summary of the 2013 CHNA have been distributed to CAC, Hospital Board members, Sequoia Hospital Foundation Board members, community partners, Sequoia Hospital leadership. Copies are available at the Sequoia Hospital Health & Wellness Center.

The Community Benefit Report FY 2014 and Implementation Plan for FY 2015 will be posted and featured on the Sequoia Hospital Website http://www.SequoiaHospital.org. This will be done following Board approval. Copies of the Community Health Needs Assessment, the Implementation Plan Summary and the annual Community Benefit Report FY2014 and Implementation Plan FY2015 are also posted on the Dignity Health website at http://www.dignityhealth.org/Who_We_Are/Community_Health/STGSS044509.

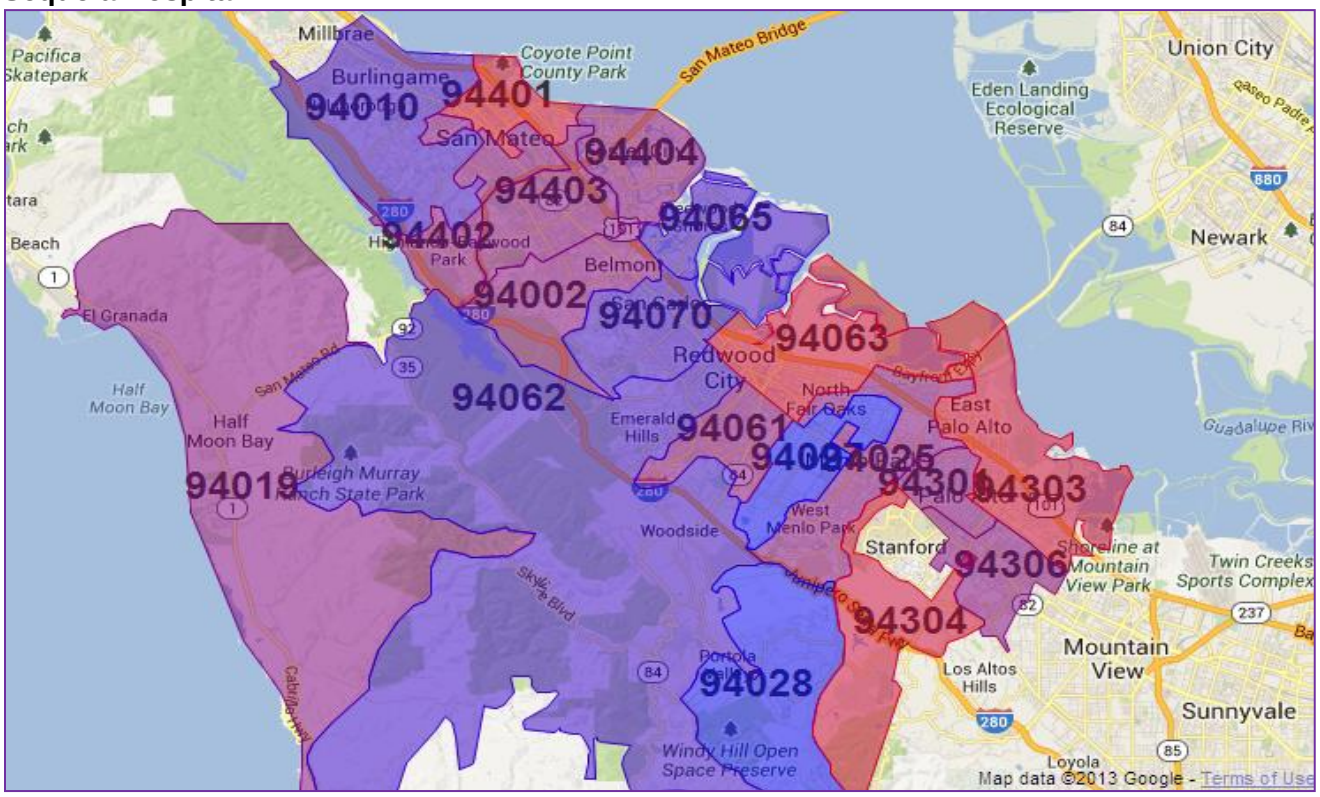
The "Inside Dignity Health Bay Area Newsletter" is utilized for internal communication. An announcement of the report and link to the website will be included. In addition, the newsletter highlights Community Benefit activities throughout the year.

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 the Community Benefit key programs will be included in the Annual Mission Integration report to be distributed to select hospital and Dignity Health committees.

Attachment A

Sequoia Hospital



Lowest Need **Highest Need**

1 - 1.7 Lowest **1.8 - 2.5 2nd Lowest** **2.6 - 3.3 Mid** **3.4 - 4.1 2nd Highest** **4.2 - 5 Highest**

	Zip Code	CNI Score	Population	City	County	State
	94002	2.6	25440	Belmont	San Mateo	California
	94010	2.4	40422	Hillsborough	San Mateo	California
	94019	3	20213	El Granada	San Mateo	California
	94025	3	40817	Menlo Park	San Mateo	California
	94027	1.6	7866	Atherton	San Mateo	California
	94028	1.4	7037	Portola Valley	San Mateo	California
	94061	3.2	34522	Redwood City	San Mateo	California
	94062	2.2	26976	San Mateo County	San Mateo	California
	94063	4	32431	Redwood City	San Mateo	California
	94065	2.4	11768	Redwood City	San Mateo	California
	94070	2.2	28382	San Carlos	San Mateo	California
	94301	2.6	16029	Palo Alto	Santa Clara	California
	94303	4	94303	Palo Alto	San Mateo	California
	94304	3.4	94304	Palo Alto	Santa Clara	California
	94306	2.8	94306	Palo Alto	Santa Clara	California
	94401	3.6	34191	San Mateo	San Mateo	California
	94402	2.6	23365	Highlands-Baywood Park	San Mateo	California
	94403	2.8	38283	San Mateo	San Mateo	California
	94404	2.6	32228	Foster City	San Mateo	California

CNI Score Median: 2.8

Attachment B

Dignity Health
Sequoia Hospital

COMMUNITY ADVISORY COMMITTEE ROSTER

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Attachment C

DIGNITY HEALTH
SUMMARY OF PATIENT PAYMENT ASSISTANCE POLICY
(June 2012)

Policy Overview:

Dignity Health is committed to providing payment assistance to persons who have health care needs and are uninsured or under-insured, ineligible for a government program, and otherwise unable to pay for medically necessary care based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable health care services, and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Payment assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with Dignity Health's procedures for obtaining payment assistance, and to contribute to the cost of their care based on individual ability to pay. Individuals with financial capacity to purchase health insurance shall be encouraged to do so as a means of assuring access to health care services.

Eligibility for Patient Payment Assistance:

- Eligibility for payment assistance will be considered for those individuals who are uninsured, ineligible for any government health care benefit program, and unable to pay for their care, based upon a determination of financial need in accordance with the policy.

- The granting of payment assistance shall be based on an individualized determination of financial need, and shall not take into account age, gender, race, or immigration status, sexual orientation or religious affiliation.

Determination of Financial Need:

- Financial need will be determined through an individual assessment that may include:
    a. an application process in which the patient or the patient's guarantor is required to cooperate and supply all documentation necessary to make the determination of financial need;
    b. the use of external publicly available data sources that provide information on a patient's or a patient's guarantor's ability to pay;
    c. a reasonable effort by the Dignity Health facility to explore and assist patients in applying for appropriate alternative sources of payment and coverage from public and private payment programs; and will take into account the patient's assets and other financial resources.

- It is preferred but not required that a request for payment assistance and a determination of financial need occur prior to rendering of services. The need for payment assistance may be re-evaluated at each subsequent rendering of services, or at any time additional information relevant to the eligibility of the patient for payment assistance becomes known.

- Dignity Health's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of payment assistance. Requests for payment assistance shall be processed promptly, and the Dignity Health facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Payment Assistance Guidelines:

Services eligible under the policy will be made available to the patient on a sliding fee scale, in accordance with financial need as determined by the Federal Poverty Level (FPL) in effect at the time of the termination as follows:

- Patients whose income is at or below 200% of the FPL are eligible to receive free care;
- Patients whose income is above 200% but not more than 350% of the FPL are eligible to receive services at the average rates of payment the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater in amount for the same services;
- Patients whose income is above 350% but not more than 500% of the FPL are eligible to receive services at 135% of the average rates the Dignity Health facility would receive from Medicare, Medicaid (Medi-Cal), Healthy Families, or any other government-sponsored health program in which the hospital participates, whichever is greater for the same services;
- Patients whose income exceeds 500% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on their specific circumstances, such as catastrophic illness or medical indigence, at the discretion of the Dignity Health facility.

Dignity Health's administrative policy for Eligibility and Application for Payment Assistance shall define what qualifies as income for these purposes.

Communication of the Payment Assistance Program to Patients and the Public:

- Information about patient payment assistance available from Dignity Health, including a contact number, shall be disseminated by the Dignity Health facility by various means, including the publication of notices in patient bills and by posting notices in the Emergency and Admitting Departments, and at other public places as the Dignity Health facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the Dignity Health facility.
- Any member of the Dignity Health facility staff or medical staff may make referral of patients for payment assistance. The patient or a family member, a close friend or associate of the patient may also make a request for payment assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient payment assistance will be included within the Social Accountability Budget of the Dignity Health facility. Dignity Health facilities will report patient payment assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient payment assistance statistics shall be disclosed in annual financial statements but shall not include amounts that are properly considered to be bad debt or contractual discounts.

Relationship to Collection Policies:

- Dignity Health system management shall develop policies and procedures for internal and external collection practices by Dignity Health facilities that take into account the extent to which the patient qualifies for payment assistance, a patient's good faith effort to apply for a governmental program or for payment assistance from Dignity Health, and a patient's good faith effort to comply with his or her payment agreements with the Dignity Health facility.

- For patients who qualify for payment assistance and who are cooperating in good faith to resolve their hospital bills, Dignity Health facilities may offer interest-free extended payment plans to eligible patients, will not impose wage garnishments or liens on primary residences and will not send unpaid bills to outside collection agencies.

Regulatory Requirements:

IN IMPLEMENTING THIS POLICY, DIGNITY HEALTH MANAGEMENT AND DIGNITY HEALTH FACILITIES SHALL COMPLY WITH ALL FEDERAL, STATE AND LOCAL LAWS, RULES AND REGULATIONS THAT MAY APPLY TO ACTIVITIES CONDUCTED PURSUANT TO THIS POLICY.