2025 Community Health Implementation Strategy and Plan

Adopted November 2025

Dignity Health
Sequoia Hospital

A member of CommonSpirit

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At-a-Glance Summary

Community Served 	Dignity Health Sequoia Hospital serves the cities in mid-county, south county, and the coastside of San Mateo County on the San Francisco Peninsula. The hospital service area includes the cities of Atherton, Belmont, Burlingame, Half Moon Bay, La Honda, Menlo Park, East Palo Alto/Palo Alto, Portola Valley, Redwood City, San Carlos and San Mateo with a total population of 524,799. While the population of the community served by Sequoia Hospital tends to be wealthier and better educated when compared to the state, there are a number of cities and unincorporated areas in the service area that experience high rates of poverty and health care disparities.
Significant Community Health Needs Being Addressed 	The significant community health needs the hospital is helping to address and that form the basis of this document were identified in the Sequoia Hospital 2025 Community Health Needs Assessment (CHNA). Needs the hospitals intends to address with strategies and programs are: • Access to Health Care • Healthy Lifestyles (Chronic Diseases and Preventive Practices) • Housing and Homelessness • Mental Health
Strategies and Programs to Address Needs 	The hospital intends to take several actions and dedicate resources to these needs, including: *Access to Health Care* Cash and in-kind donations to community nonprofit organizations Community Health Improvement Grants program Financial assistance for the uninsured or underinsured Health Professions Education Program Operation Access (donated surgical and specialty care) Workforce Development Program *Healthy Lifestyles (Chronic Diseases and Preventive Practices)* A Matter of Balance Blood Glucose Meter Instructions Cash and in-kind donations to community nonprofit organizations Community health education and support groups Community Health Improvement Grants program Diabetes Empowerment Education Program (D.E.E.P.) LiveWell Program

Housing and Homelessness

Cash and in-kind donations to community nonprofit organizations
Community Health Improvement Grants program
Discharge planning for people experiencing homelessness

Mental Health

Cash and in-kind donations to community nonprofit organizations
Community Health Improvement Grants program
New Parents support group

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

This document is publicly available online on the hospital's website. Written comments on this strategy and plan can be submitted to the Dignity Health Sequoia Hospital, Health & Wellness Department, 170 Alameda de las Pulgas, Redwood City, CA 94062 or by e-mail to sequoia-commhealth@commonspirit.org

Our Hospital and the Community Served

About the Hospital

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

- Dignity Health Sequoia Hospital is located at 170 Alameda de las Pulgas, Redwood City, California, 94062.
- The hospital facility is licensed for 208 beds.
- Sequoia's Heart and Vascular Institute is a nationally known pioneer in advanced cardiac care. The Birth Center is consistently ranked as a favorite among Peninsula families, and the hospital is also known for the Center for Total Joint Replacement and comprehensive emergency care.

Our Mission

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

Financial Assistance for Medically Necessary Care

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

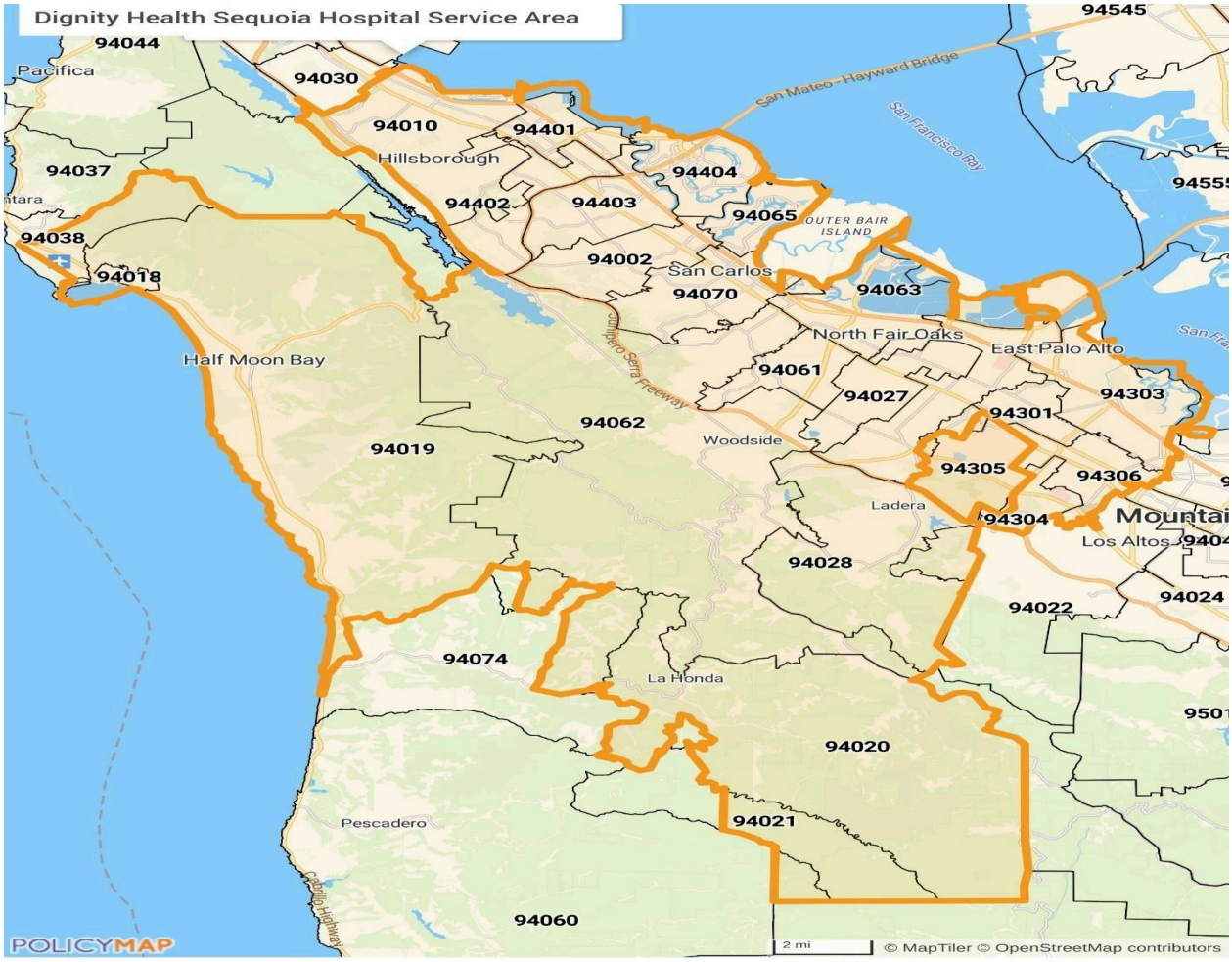
This hospital has a financial assistance policy that describes the assistance provided to patients for whom it would be a financial hardship to fully pay the expected out-of-pocket expenses for such care, and who meet the eligibility criteria for such assistance. The financial assistance policy, a plain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

Description of the Community Served

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

Sequoia Hospital Service Area

Place	ZIP Code	County
Atherton	94027	San Mateo
Belmont	94002	San Mateo
Burlingame	94010	San Mateo
Half Moon Bay	94019	San Mateo
La Honda	94020	San Mateo
Menlo Park	94025	San Mateo
East Palo Alto/Palo Alto	94301, 94303, 94304, 94306	San Mateo/Santa Clara
Portola Valley	94028	San Mateo
Redwood City	94061, 94062, 94063, 94065	San Mateo
San Carlos	94070	San Mateo
San Mateo	94401, 94402, 94403, 94404	San Mateo



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

The population of the service area is 524,799. Children and youth, ages 0-17, make up 21.8% of the population, 61.9% are adults, ages 18-64, and 16.3% of the population are seniors, ages 65 and older. The largest portion of the population in the service area is White or Caucasian residents (44.7%), 23.7% of the population are Asian residents and 22.2% are Hispanic or Latino residents. 5.2% of the population identifies as multiracial (two-or-more races), 2.3% are Black or African American residents, 1% are Native Hawaiian or Pacific Islander residents, and 0.1% are American Indian or Alaskan Native residents.

Among the residents in the service area, 6.1% are at or below 100% of the federal poverty level (FPL) and 13.9% are at 200% of FPL or below. In the service area, 5.9% of children live in poverty, 7.8% of senior adults live in poverty, and 16.1% of families with female head of household with minor children live in poverty. The unemployment rate in the service area among the civilian labor force, averaged over 5 years, is 4.4%. The median household income in the service area is $177,626.

In the service area, 96.6% of the civilian, non-institutionalized population have health insurance, and 98.1% of children, ages 18 and younger, have health insurance coverage. Among county residents, 9.9% have Medi-Cal coverage.

Educational attainment is a key driver of health. In the hospital service area, 8% of adults, ages 25 and older, lack a high school diploma, which is lower than the state rate (15.6%). 63.1% of area adults have a bachelor's or higher degree.

The U.S. Health Services Administration (HRSA) designates medically underserved areas/populations (MUA) as areas or populations having too few primary care providers, high infant mortality, high poverty, or a high elderly population. San Mateo County is designated as an MUA for primary care.

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

Community Assessment and Significant Needs

The health issues that form the basis of the hospital's community health implementation strategy and plan were identified in the most recent CHNA report, which was adopted in May 2025. The CHNA report includes:

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

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

Significant Health Needs

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

Significant Health Need	Description	Intend to Address?
Access to Care	Access to health care refers to the availability of primary care, specialty care, vision care and dental care services. Health insurance coverage is considered a key component to ensure access to health care. Barriers to care can include lack of transportation, language and cultural issues.	●
Chronic Diseases	A chronic disease or condition usually lasts for three months or longer and may get worse over time. Chronic diseases can usually be controlled but not always cured. The most common types of chronic diseases are cancer, heart disease, stroke, diabetes, and arthritis.	●
Housing and Homelessness	*Homelessness* is known as a state of being unhoused or unsheltered and is the condition of lacking stable, safe, and adequate housing.	●
Mental Health	*Mental health* includes our emotional, psychological, and social well-being. It affects how we think, feel, and act.	●
Overweight and Obesity	Overweight and obesity are common conditions that are defined as the increase in size and	

Significant Health Need	Description	Intend to Address?
	amount of fat cells in the body. Obesity is a chronic health condition that raises the risk for chronic diseases. Overweight and obesity are linked to a lack of physical activity and unhealthy eating habits.	
Preventive Practices	Preventive practices refer to health maintenance activities that help to prevent disease. For example, preventive care includes vaccines, routine health screenings and injury prevention strategies.	●
Substance Use	Substance use is the use of tobacco products, illegal drugs, prescription drugs, over-the-counter drugs or alcohol. Excessive use of these substances or use for purposes other than those for which they are meant to be used, can lead to physical, social or emotional harm.	
Tuberculosis	Tuberculosis (TB) is a contagious bacterial infection that usually attacks the lungs.	

Significant Needs the Hospital Does Not Intend to Address

Taking existing hospital and community resources into consideration, Sequoia Hospital will not directly address the remaining significant health needs identified in the CHNA, which include overweight and obesity, substance use, and tuberculosis. Knowing there are not sufficient resources to address all the community health needs, Sequoia Hospital chose to concentrate on those health needs that can most effectively be addressed given the organization's areas of focus and expertise. The hospital has insufficient resources to effectively address all the identified needs and, in some cases, the needs are being addressed by others in the community.

2025 Implementation Strategy and Plan

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

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

Creating the Implementation Strategy

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

Sequoia Hospital engaged the community health team, hospital executive leaders and the Community Advisory Committee to examine the identified health needs according to these criteria. The CHNA served as the resource document for the review of health needs as it provided statistical data on the severity of issues and also included community input on the health needs. As well, the community prioritization of the needs was taken into consideration.

The programs and initiatives described here were selected based on:

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

Community Health Core Strategies

The hospital believes that program activities to help address significant community health needs should reflect a strategic use of resources. CommonSpirit Health has established three

core strategies for community health improvement activities. These strategies help to ensure that program activities overall address strategic aims while meeting locally identified needs.

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

Vital Conditions and the Well-Being Portfolio

Community health initiatives at CommonSpirit Health use the Vital Conditions framework and the Well-Being Portfolio[1] to help plan and communicate about strategies and programs. Investments of time, resources, expertise and collaboration to improve health and well-being can take different approaches. And usually, no single approach can fully improve or resolve a given need on its own.

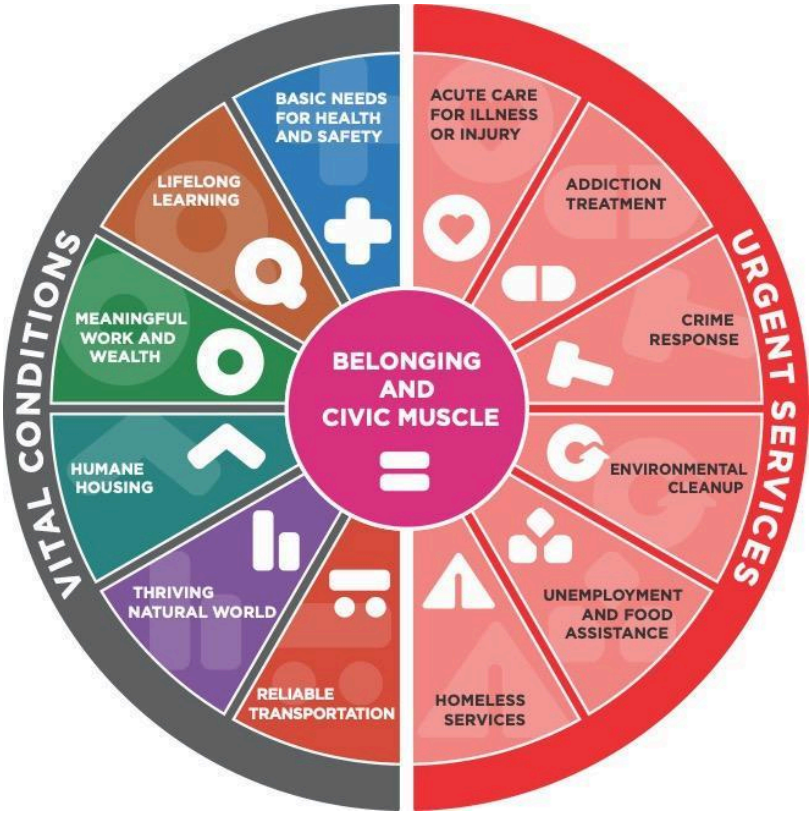
One way to think about any approach is that it may strengthen "vital conditions" or provide "urgent services," both of which are valuable to support thriving people and communities. A set of program activities may seek to do one or both. Taken together, vital conditions and urgent services compose a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

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

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

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

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



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

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

Strategies and Program Activities by Health Need

Health Need	**Access to Health Care**				
Population(s) of Focus	Individuals who experience barriers to accessing health care services. Uninsured and underinsured people.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: Extend care continuum	**Strategy 2: Evidence-informed**	**Strategy 3: Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Charitable cash and in-kind donations	Provides cash and in-kind donations to community-based organizations to address access to health care.	•	•	•	VC & US
Community Health Improvement Grants program	Offers grants to nonprofit community organizations that provide access to health care programs and services.	•	•	•	VC & US
Financial assistance for the uninsured or underinsured	Provides financial assistance to those who have health care needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay.	•		•	US
Health Professions Education Program	Offers a clinical setting for training and educating nursing students and other allied health professionals.		•	•	VC
Operation Access	Partners with Operation Access to link donated surgical preventive care to uninsured and underinsured patients in San Mateo County at no charge to patients.	•		•	US
Workforce Development	In partnership with Wender Weis Foundation for		•	•	VC

	Children, the program builds awareness with local high school students for entry level jobs in health care fields.				
Planned Resources	The hospital will provide registered nurses, enrollment counselors, community health educators, case managers, grants, outreach communications, preceptors, and program management support.				
Planned Collaborators	Schools and universities training health care professionals, community-based organizations, health advisory councils, Operation Access, San Mateo County Health, high schools and school districts, Wender Weis Foundation for Children				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase access to health care for the medically underserved and reduce barriers to care.	Reduce from 18.9% to 5.9% the proportion of people who can't get medical care when needed.	Healthy People 2030

Health Need	Healthy Lifestyles (Chronic Disease and Preventive Practices)				
Population(s) of Focus	Individuals with chronic diseases and their families, people at risk of developing chronic diseases. Individuals who experience barriers to accessing preventive care services.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
A Matter of Balance	Provides an evidence-based program designed to reduce the fear of falling and increase activity levels among older adults.	●		●	VC
Blood Glucose Meter instructions	Provides a free blood glucose meter and instruction on blood glucose monitoring and goals.	●	●	●	VC
Charitable cash and in-kind donations	Provides cash and in-kind donations to community-based organizations to address healthy lifestyles (chronic diseases and preventive practices).	●	●	●	VC
Community health education and support groups	Provides health education sessions and support groups to the public that focus on healthy behaviors, disease prevention and management, and injury prevention.	●	●	●	VC
Community Health Improvement Grants program	Offers grants to nonprofit community organizations that provide healthy lifestyles (chronic diseases and preventive practices) programs and services.	●	●	●	VC
Diabetes Empowerment Education Program	An evidence-based program for diabetes self-management practices.	●	●	●	VC

Health Need	**Healthy Lifestyles (Chronic Disease and Preventive Practices)**				
(D.E.E.P.)					
LiveWell Program	Helps residents of San Mateo County achieve their goals for health and wellness. Focuses on healthy behaviors, disease prevention and management, and injury prevention. Activities and programs include: ● Health screenings ● Evidence-based prevention program(s) ● Community health education and support groups ● Health advocacy	●	●	●	VC
Planned Resources	The hospital will provide registered nurses, community health educators, dietitians, case managers, physical therapists, grants, outreach communications, and program management support for these initiatives.				
Planned Collaborators	Fall Prevention Coalition of San Mateo County, senior centers, community centers, schools and school districts, San Mateo County Tobacco Prevention Program, Sequoia Healthcare District, San Mateo County Health, parks, recreation and community services.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase the number of adults who get recommended preventive health care.	Increase from 75.5% to 80.3% of women who receive recommended mammograms. Increase from 64% to 68.3% of adults who receive recommended colorectal cancer screenings.	Healthy People 2030

Health Need	**Housing and Homelessness**				
Population(s) of Focus	Individuals and families who are at risk of homelessness or experiencing homelessness.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Charitable cash and in-kind donations	Provides cash and in-kind donations to community-based organizations to address housing and homelessness.	●		●	VC & US
Community Health Improvement Grants program	Offers grants to nonprofit community organizations that provide housing and homelessness programs and services.	●	●	●	VC & US
Discharge planning for homeless patients	Offers supportive services that include a meal, weather-appropriate clothing, medications, transportation, infectious disease screening, vaccinations and screening for affordable health care coverage. For shelter resources, the San Mateo County Coordinated Entry System is called for assistance. Engages the services of LifeMoves "Homeless Outreach Team" (HOT) to provide services, which include outreach and engagement, intensive case management (including support in following up on medical appointments), benefits enrollment, and transportation to and from medical appointments.	●	●	●	VC & US
Planned Resources	The hospital will provide care coordinators, social workers, grants, outreach communications, and program management support.				

Health Need	**Housing and Homelessness**
Planned Collaborators	Community-based organizations, housing and homeless services agencies, community centers, San Mateo County Behavioral Health & Recovery Services, LifeMoves, public safety, and community clinics.

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Reduce the proportion of families that spend more than 30 percent of income on housing	Reduce from 34.6% of families to 25.5% of families that spend more than 30% of income on housing.	Healthy People 2030

Health Need	**Mental Health**				
Population(s) of Focus	Individuals and families who are at risk for and/or experiencing mental health distress.				
Strategy or Program	Summary Description	Strategic Alignment			
		Strategy 1: **Extend care continuum**	Strategy 2: **Evidence-informed**	Strategy 3: **Community capacity**	**Vital Condition (VC) or Urgent Service (US)**
Charitable cash and in-kind donations	Provides cash and in-kind donations to community-based organizations to address mental health issues.	●		●	VC & US
Community Health Improvement Grants program	Offers grants to nonprofit community organizations that provide mental health programs and services.	●	●	●	VC & US
New Parents support group	Helps new parents navigate the challenges of parenting in a structured, inclusive, strength-based and empowering group experience.	●	●	●	VC & US
Planned Resources	The hospital will provide health educators, grants, outreach communications, and program management support.				
Planned Collaborators	Schools and school districts, community-based organizations, community centers, counseling services, Mental Health Association of San Mateo County, youth programs, law enforcement, and collaboratives that seek to support mental health.				

Anticipated Impacts (overall long-term goals)	Measure	Data Source
Increase prevention, screening, assessment, and treatment of mental health disorders.	Increase from 38.7% of adults to 65.6% of adults, ages 18 and older with depression, who receive treatment.	Healthy People 2030