



Sequoia Hospital

Community Benefit Report 2012
Community Benefit Implementation Plan 2013

A message from the President, Sequoia Hospital and Board Chair

At Sequoia Hospital we share a commitment to optimize the health of the community we are privileged to serve. Vital to this effort is the collaboration we enjoy with our community partners. How we contribute to the quality of life and the environment in our communities has always been a key measure of our success and it will continue to be so as we move forward.

In January 2012 Dignity Health, formerly Catholic Healthcare West, announced changes in our governance structure and name that will better position the system to welcome new partners in a changing health care landscape. The new name, Dignity Health, was chosen because dignity has been one of our core values since our founding. It is deeply embedded in our culture and clearly describes who we are and what we stand for. Our new governance structure more accurately reflects our current composition of both religiously sponsored and community sponsored hospitals.

During fiscal year 2012, we, like the nation, were impacted by the continuing economic downturn and experienced both successes and challenges. Despite declining revenue from government sponsored patients, we provided 43,363,809 million in charity care, community benefits, and unreimbursed patient care.

At Sequoia Hospital we strive to manage our resources and advance our healing ministry in a manner that benefits the common good now and in the future. Despite today's challenges we see this as time of great hope and opportunity for the future of health care. We want to acknowledge and thank the women and men who have worked together in a spirit of collaboration to address the health priorities of our community through health and wellness programs and services.

In accordance with policy the Sequoia Hospital Board of Directors has reviewed and approved the annual Community Benefit Report and Implementation Plan at their November 7, 2012 meeting.

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

Sequoia Hospital, founded in 1950, is located at 170 Alameda de las Pulgas, Redwood City, CA. It affiliated with Dignity Health, formerly Catholic Healthcare West (CHW)¹ 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 is 72 (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 expanded emergency services and larger, private patient rooms. Sequoia has a staff of 977 employees and professional relationships with more than 557 local physicians. Major hospital services include a Heart and Vascular Institute, Birth Center, and Emergency Services.

During FY 2012, 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.

Sequoia's Adult Screening and Vaccines program, which includes monthly blood pressure checks by a registered nurse at six senior and community centers, addresses the need for Chronic Disease Prevention and Management. Screenings include one-on-one education and physician referrals for those with abnormal blood pressure. Other services include diabetes and cholesterol screenings and education about stroke, advance directives, nutrition and medication management. We also hold seasonal flu, pneumococcal and Tdap vaccine clinics in the community, focusing on high risk populations.

Sequoia has chosen two ambulatory sensitive conditions, diabetes and congestive heart failure, to address with Long Term Improvement Plans (LTIP). The Live Well with Diabetes Program includes a five-week, community-based diabetes management and prevention course which addresses the increasing prevalence of diabetes, especially among low-income and Latino community members. The evidence-based class is the result of collaboration between Sequoia Hospital and three community agencies. In FY12, 14 classes taught in English and Spanish by trained diabetes health promoters reached 154 community members. During follow-up phone interviews six months after completion of the class, 33 students contacted reported having no hospital admissions or emergency room visits for diabetes. Curriculum for Living with Congestive Heart Failure classes was developed by Sequoia Hospital's registered nurses, pharmacist and registered dietitian to provide a coordinated continuum of care with the education provided to our in-patients. The two session class is facilitated by Sequoia Hospital's Health & Wellness Center Community Health Nurse with a pharmacist and a registered dietitian. Our major challenge has been recruitment of participants.

Healthy Aging in Place for older adults is addressed by the Sequoia Hospital Homecoming Program (SHHP), Fall Prevention classes and active participation on the San Mateo County Fall Prevention Task Force, which Sequoia formed in 2003. The SHHP program is a hospital-to-home transitional care service provided through a collaboration of not-for-profit agencies working together to bridge the gap between hospital and a strong recovery for older adults discharged from Sequoia Hospital. This program is supported by the Dignity Health/Sequoia Hospital Community Grants Program. During July 2011–June 2012, 76 referrals were made to SHHP. Services were accepted by 59 patients. Our success is measured by a low 5% readmission rate within 30 days, along with high satisfaction reported by those served. Equally important is the cross-referral network, which has been created by the relationships of our collaborative partners and serves the entire community.

Our priority of Child/Youth Healthy Development begins with our support of families during pregnancy and continues with our strong Lactation Education and Support Programs and our New Parent's Support groups. New parents have named the support group "The Village" and it extends far beyond the walls of Sequoia Hospital.

¹ For more information on the name change, please visit www.dignityhealth.org

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. The Make Time for Fitness Program is a fun and educational, multi-faceted program which reinforces the theme of "Eat Healthy, Stay Active, Be Tobacco Free." Sequoia Hospital Health & Wellness conducted vaccination clinics at Redwood City Schools (a DUHN neighborhood) to serve 73 minors and helped the school district achieve 100% compliance with the state mandated immunization requirements for 7th and 8th grade students. At the request of the Sequoia Union High School District (SUHSD) school nurses and wellness coordinator, Sequoia Hospital's Pulmonary Rehabilitation Department has started an asthma education and management program. In Spring 2012, initial training was provided for physical education department leaders and health aides at the high schools.

Sequoia Hospital is effectively able to carry out these identified 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 FY13 will continue to support and enhance initiatives which continue to address needs identified in the 2011 Community Needs Assessment.

The total dollars quantified for Community Benefit in FY12 is \$43,363,809.

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 Council (CAC).

The CAC consists of 20 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 2012 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 who 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 education programs. The Health & Wellness coordinator is responsible for data collection, reporting and analysis. The chaplain manager of Spiritual Care and 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, design, targeting, monitoring and 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, internationally board certified lactation consultants, registered dietitians, certified childbirth educators, CPR instructors and occupational therapists. Staff from departments of Sequoia Hospital, including the Diabetes Center, Pulmonary Rehabilitation, Spiritual Care, and Nutrition Services respond to requests for community benefit programs.

Advisory to the Health & Wellness staff are members of the Community Advisory Council (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 on sub-committees for key Community Benefit programs to provide review and oversight.

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; Sequoia's strategic plan and building updates; and CAC review and approval of the Annual Community Benefit Report and 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 oversees the 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).
- Sequoia's Lactation Center Nurse Coordinator served on the San Mateo County Breastfeeding Advisory Committee. The Advisory Committee works on the GHSMC 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 (formerly Youth and Family Enrichment Services), 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 16 years and was chair in 2009.

Sequoia Hospital's effort to protect the environment was an additional way we expressed our commitment to Community Benefit. In 2012, Sequoia received the national Environmental Leadership Circle Award for the fourth year from Practice GreenHealth, the premier award recognizing health care organizations for outstanding programs to reduce a facility's environmental footprint. Award winners must meet the criteria for the mercury-free award, recycle at least 25% of their total waste, implement numerous other innovative pollution prevention programs, and be leaders in their community. Sequoia also received the California Waste Reduction (CA WRAP) award, which is given to California companies that reduce at least 25% of their total waste. We helped protect our hospital environment when we switched from gas vehicles to electric vehicles used for our Valet Service.

Sequoia Hospital's generosity extends beyond our local community to developing countries in other parts of the world. In FY12, Sequoia donated 5,500 pounds of unused medical equipment to MedShare International. We also donated our used toner cartridges to an elementary school, which they recycled and received funds to provide educational supplies, special education funding, parent education, the art docent program, and transportation for class field trips.

COMMUNITY

Dignity Health hospitals define the “community” as the primary geographic area served by the hospital, representing 80% of hospital in-patient discharges. Sequoia’s primary service area represents a broader geographic reach than most community hospitals because of the reputation and wide referral base for Sequoia’s Heart and Vascular Institute. Therefore, Sequoia’s primary service area is not contiguous and reflects a slightly younger patient base than the immediate surrounding communities it serves. The primary service area definition is used for hospital strategic planning.

ZIP Code	ZIP City Name	St	Inpatients Count	Inpatients %
94070	San Carlos	CA	947	10.3%
94061	Redwood City	CA	937	10.2%
94062	Redwood City	CA	722	7.9%
94002	Belmont	CA	563	6.2%
94063	Redwood City	CA	489	5.3%
94025	Menlo Park	CA	473	5.2%
94404	San Mateo	CA	469	5.1%
94403	San Mateo	CA	347	3.8%
94065	Redwood City	CA	250	2.7%
94402	San Mateo	CA	183	2.0%
94303	Palo Alto	CA	181	2.0%
94401	San Mateo	CA	133	1.5%
94010	Burlingame	CA	117	1.3%
94301	Palo Alto	CA	101	1.1%
94306	Palo Alto	CA	101	1.1%
94019	Half Moon Bay	CA	97	1.1%
94027	Atherton	CA	85	0.9%
94028	Portola Valley	CA	73	0.8%
94066	San Bruno	CA	71	0.8%
94080	S San Francisco	CA	66	0.7%
94043	Mountain View	CA	59	0.6%
94022	Los Altos	CA	52	0.6%
94040	Mountain View	CA	51	0.6%

ZIP Code	ZIP City Name	St	Inpatients Count	Inpatients %
94086	Sunnyvale	CA	48	0.5%
94536	Fremont	CA	46	0.5%
94044	Pacifica	CA	42	0.5%
94587	Union City	CA	40	0.4%
94024	Los Altos	CA	37	0.4%
94085	Sunnyvale	CA	36	0.4%
94560	Newark	CA	35	0.4%
94087	Sunnyvale	CA	34	0.4%
94304	Palo Alto	CA	34	0.4%
95051	Santa Clara	CA	34	0.4%
95136	San Jose	CA	33	0.4%
94030	Millbrae	CA	32	0.3%
94538	Fremont	CA	31	0.3%
95014	Cupertino	CA	31	0.3%
95123	San Jose	CA	30	0.3%
95037	Morgan Hill	CA	30	0.3%
95126	San Jose	CA	29	0.3%
95023	Hollister	CA	28	0.3%
94089	Sunnyvale	CA	27	0.3%
94014	Daly City	CA	27	0.3%
94015	Daly City	CA	26	0.3%
94041	Mountain View	CA	26	0.3%
95125	San Jose	CA	26	0.3%

Sequoia Hospital’s Primary Service Area is comprised of suburban communities:

- Population: 1,678,813
- Diversity: White Non-Hispanic (38.5%); Black Non-Hispanic (2.6%); Hispanic (24.4%); Asian & Pacific Islander (30.4%); Other 4.0%
- Average Income: \$113,369.00
- Uninsured: 8.41%
- Unemployment: 5.3%
- No HS Diploma: 11.4%
- Renters: 38.9%
- CNI Score: 3.0 (mid-need)
- Medicaid Patients: Medicaid/Medical/AHCCCS Patients (3.59%); Medicare (55.62%); Commercial (38.63%); (Note: The payor category percentages are for 7/1/11-3/31/12).

Other hospitals within the community that are able to respond to the health needs of the community are Mills-Peninsula Medical Center; Lucile Salter Packard Children’s Hospital at Stanford; Stanford Hospital; Kaiser Permanente Hospitals in Redwood City, South San Francisco, and Santa Clara; San Mateo Medical Center; California Pacific Medical Center-Pacific Campus; and UCSF Medical Center.

San Mateo County is not designated as a Medically Underserved Area (MUA) or Medically Underserved Population (MUP).

COMMUNITY BENEFIT PLANNING PROCESS

A. Community Health Needs Assessment Process

The Healthy Community Collaborative (HCC) of San Mateo County (SMC), a group of 15 San Mateo County organizations interested in community health, produced the 2011 (sixth) edition of a county-wide health needs assessment. Sequoia Hospital has been a member of the HCC since it was convened in 1994. HCC member organizations participating in the 2011 Community Assessment were Stanford Hospital & Clinics; Peninsula Health Care District; SMC Human Service Agency; Seton Medical Center; Sequoia Hospital; Sequoia Healthcare District; Health Plan of San Mateo; SMC Health Department; Peninsula Library System-Community Information Program; Mills-Peninsula Health Services; San Mateo Medical Center; Lucile Packard Children's Hospital; Hospital Consortium of SMC; Youth & Family Enrichment Services/StarVista; and Kaiser Foundation Hospital/Health Plan.

The HCC has overseen the triennial Community Health Needs Assessment: Health & Quality of Life in San Mateo County since 1995. In conducting the 2011 Community Assessment: Health & Quality of Life in San Mateo County, the goals of the HCC were twofold:

- 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
- promote collaborative efforts in the community and develop collaborative projects based on the data, community input and group consensus.

Two research methodologies were applied to produce the final analyses found in this report. The first five chapters involved analysis of the most current data from various sources to produce and update the graphs and tables. All rates in these analyses are age-adjusted unless otherwise noted and are standardized using the Year 2000 United States Population standards. The last chapter shows 2011 projections for selected indicators from the Health and Quality of Life Survey that were selected by the HCC to be studied in this assessment. Data from the previous four reports (1998, 2001, 2004, and 2008) were used to produce trend lines and obtain regression equations for selected quality of life indicators. The equations were then used to project the trends for 2011. This study is part of a larger and longitudinal study, encompassing many years worth of data and trends and should be viewed in that context. It is recognized that these are projections only and they are interpreted and used with caution.

“Community health” in this assessment is not limited to traditional health measures. This definition includes indicators relating to the quality of life, environmental and social factors that influence health, as well as the physical health of the county's residents. This reflects the HCC's view that community health is affected by many factors and cannot be adequately understood without consideration of trends outside the realm of health care.

The HCC is currently planning the next Community Health Needs Assessment: Health & Quality of Life in San Mateo County for release in March 2013. This will bring together a wide array of community health and quality of life indicators in San Mateo County gathered from both primary and secondary data sources.

The 2011 Community Assessment affirms that San Mateo County compares favorably to our state and the nation on many health and quality of life measures. For a majority of San Mateo County 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 San Mateo County 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.

The results of the 2011 Community Health Needs Assessment, additional secondary research and information gained from primary research activities conducted by our community partners have enabled Sequoia Hospital to understand more fully the well-being of the communities within its core service area. Key findings offered throughout the Assessment focus on the most salient challenges facing health and quality of life in these communities. Many findings also provided “treatment recommendations” for overcoming these challenges. A few notable findings include:

- The actual causes of premature death are rooted in behavior, and it is estimated that as many as 50% of premature deaths are due to health risk behaviors such as tobacco use, poor diet, a lack of exercise, alcohol use, etc. The vast majority of our community does not exhibit the most basic healthy behaviors. Individual health behaviors are deeply influenced by public policy and place. The health of San Mateo County can be improved through a greater focus by all organizations on public policy changes and place-based strategies.
- Our children are not doing much better than adults in exhibiting healthy behaviors. This will severely impact their future health, as well as the utilization of healthcare services.
- Falls are a key issue leading to hospitalization, loss of independence, and death among seniors. More resources should be directed toward this preventable condition.
- Heart disease and stroke death rates continue to decline, while reported prevalence of high blood pressure and high blood cholesterol continues to rise.
- By the year 2030, the number of adults over age 65 will increase by 72% and the number over age 85 will increase to two and a half times the current number. Our county will have a greater proportion of older adults than the state average. Hispanics and Asians are projected to increase their representation considerably in the older population. Increased rates of chronic diseases and cognitive impairments are expected and will result in a dramatic increase in demand for healthcare and community-based services.

Sequoia Hospital also utilizes the Community Need Index (CNI), a tool developed by Dignity Health to measure community need in a geographic market, analyzes the degree to which a community faces barriers to healthcare 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 3.0. The community in Sequoia Hospital’s primary service and close geographic boundary area that is identified in highest need is zip code (94063) Redwood City with a CNI of 4.

(See Attachment A for Sequoia’s CNI map and scores by zip code.)

The 2011 Community Health Needs Assessment of the San Mateo County Community (full report and all previous reports) is available at www.smhealth.org/hpp or <http://www.plsinfo.org/healthysmc>

B. Assets Assessment

The HCC did not conduct a formal assets assessment; however, the HCC meets monthly and invites presentations from community service organizations and groups to inform us about their work in the community. These have included: Review of the San Mateo County 211 Community Information System website, Get Healthy San Mateo County Task Force, Walk to School Day Committee, San Mateo County Fall Prevention Task Force Strategic Plan and Update, Hospital Wellness Programs, Grand Boulevard Initiative, Volunteer Drivers Program, North Fair Oaks Community Plan, AAS Older Adults Needs Survey Update, Santa Clara County Update on Community Health Needs Assessment; San Mateo County Food Alliance; Streets Alive; Peninsula Clergy Network Input on Health Issues. Hospital representatives report on their community benefit programs and priorities on a regular basis which allows for collaboration when appropriate and avoidance of duplication of services.

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

The process that Sequoia Hospital utilizes to prioritize our community benefit activities is a dynamic one which is ongoing throughout the year. Programs are constantly being evaluated utilizing in-put from our community advisors, partners, newly published data and our own program outcome measures data. This approach has allowed us to respond to identified needs by revising program strategies and adding enhancements on a regular basis. The information provided by the 2011 Community Assessment validated that our major initiatives remain relevant and our services will continue to address identified unmet health-related needs of our community.

Sequoia Hospital is effectively able to carry out these identified Community Benefit activities with our institutional assets, resources, capabilities 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 priority areas and key programs that will address health issues in FY13:

- 1. Preventing and/or Managing Health Conditions:**
 - Blood Pressure, Diabetes and Cholesterol Screenings and Education at six Senior and Community Centers
 - Adult Immunization Clinics for Influenza, Pneumonia, Tetanus, Diphtheria, Pertussus
 - Spanish language Live Well with Diabetes Classes
 - Smoking Cessation Classes
 - Eating for Health at St. Anthony's Padua Dining Room (94063 Redwood City)
 - Fair Oaks Intergenerational Activity Center Breakfast Program (94063 Redwood City)
 - Living with Congestive Heart Failure Program
- 2. Healthy Aging in Place:**
 - Sequoia Hospital Homecoming Program (SHHP)
 - Dignity Health/Sequoia Hospital Community Grants Program for non-profit organizations
 - Sequoia Hospital's Fall Prevention Classes and San Mateo County Fall Prevention Task Force
- 3. Child/Youth Healthy Development:**
 - Lactation Education Center; WIC Partnership for Lactation Consultations
 - New Parents Support Groups
 - Make Time for Fitness Program-School Partnerships with emphasis on Community Schools in Redwood City School District
 - Tdap vaccine clinics for school age children
 - Sequoia Union High School District: Programs for addressing asthma, diabetes, CPR training for teachers and students and management of concussions
- 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 Healthcare:**
 - Charity Care 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 Healthy Living 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

It is our intention that programs that we sponsor for both the Broad and Vulnerable Community will contribute to containing the growth of community health care costs. 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 alcohol, drug and mental health issues presented in the 2011 Assessment because they are beyond the scope of our facility and are being addressed by other organizations in the community.

D. 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.

Policy Overview

Dignity Health is committed to providing financial assistance to persons who have healthcare needs and are uninsured, under-insured, ineligible for a government program, or otherwise unable to pay for medically necessary care, based on their individual financial situations. Consistent with its mission to deliver compassionate, high quality, affordable healthcare services and to advocate for those who are poor and disenfranchised, Dignity Health strives to ensure the financial capacity of people who need healthcare services does not prevent them from seeking or receiving care. Payment assistance is not considered 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.

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.

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 FY12. Programs intended to be operated in FY13 are noted by *. Programs were developed in response to the current 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 problem.
- 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 Centers and Health & Wellness*
- Cholesterol Screenings*
- Diabetes Screenings*
- Adult Immunizations: Flu, Pneumococcal, Tdap, Hep B*
- Smoking Cessation Classes*
- Live Well with Diabetes*
- Living with Congestive Heart Failure Program*

Initiative 2: Healthy Aging in Place

As the fastest-growing population segment, the health and social needs of older adults require increasing attention.

- Fall Prevention Classes*
- Sequoia Hospital Homecoming Program*
- Dignity Health/Sequoia Hospital Community Grants Program*
 - Family Service Agency (Case Management)
 - Samaritan House Free Clinic Redwood City (Transitional Care Coaching)
 - Peninsula Volunteers (Meals on Wheels)
 - Second Harvest Food Bank (Brown Bag Program)
 - Rebuilding Together Peninsula (Safe at Home)

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 Groups*
- Make Time for Fitness*
- Walking Courses at schools *
- Sequoia Hospital Youth Volunteers/Mentoring*
- CPR Training in Sequoia Union High School District*
- Asthma management education at Sequoia Union High School District*
- Tdap in Redwood City middle schools to achieve 100% compliance with state law

Initiative 4: Community Building Activities*

Sequoia Hospital is committed to building a healthier community through working collaboratively with community partners, 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*
- 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*

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 FY12, Sequoia provided \$370,955.62 in free services for 1,823 patients. Without Sequoia's support these services would not be available to the clinic's patients. In addition, the Sequoia Hospital Diabetes Center provides free one-on-one consultations and blood glucose meter instruction for patients who are unable to pay for these services.

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 such as AARP Driver Safety Program, 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, Prostate Cancer Information Forum, Nursing Mothers Counsel, La Leche League and Hope House. The Health & Wellness Center's free meeting space served 3,422 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 seven 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 4,070 individuals with more than \$172,959 in breastfeeding support services. Lactation staff also facilitate the New Parents Support Group offered at the Health & Wellness Center. This past year 1,964 new parents participated in this free group which provides an important source of 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 FY2012, Sequoia staff mentored students in the following areas: central supply; clinical chaplaincy, wound care, lab science, phlebotomy, paramedic, pharmacy, physical therapy, physicians assistants, radiation oncology, radiology, nursing and respiratory therapy. In total, more than 24,722 hours valued at \$1,472,921 was dedicated to the direct training of 126 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 2013 promises to offer more opportunities to explore Community Benefit 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 Council (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:

- Make Time for Fitness
- Sequoia Hospital Homecoming Program
- Fall Prevention
- Live Well with Diabetes
- Adult Screenings & Vaccines

PROGRAM DIGEST

Make Time for Fitness	
Hospital CB Priority Areas	<ul style="list-style-type: none"> <input type="checkbox"/> Chronic Disease Prevention & Management <input type="checkbox"/> Healthy Aging in Place <input checked="" type="checkbox"/> Child/Youth Healthy Development <input checked="" type="checkbox"/> Community Building
Program Emphasis	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>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.</p> <p>In 2010-11, enrollment in Redwood City School District’s (RCSD) 16 schools was 9,273 K-8th grade students:</p> <ul style="list-style-type: none"> • 80% minority students • 72% are Hispanic/Latino • 48% are English Language Learners • 61% qualify for free or reduced price meals (this rate was 47% in 2000). <p>Community schools (Fair Oaks, Hoover, Kennedy, and Taft) have student and family populations among the highest need in the district. They all have a very high percentage of students who qualify for free or reduced price lunch, with the highest rate at Fair Oaks (93%). English Language Learners at Fair Oaks are (87%). Hispanic/Latino students attending Fair Oaks (93.3%); Hoover (93.3%) and Taft (94.5%).</p> <p>RCSD 5th and 7th grade students were tested in the spring of 2011, and according to the 2011 Physical Fitness Test results reported for RCSD by the California Department of Education, only 20.8% of 5th grade students and 21.5% of 7th grade students scored in the Healthy Fitness Zone (HFZ) for six out of six fitness areas. The HFZ is the level of fitness sufficient for good health. Standards measured by this test represent a level of fitness that offers protection against disease associated with physical inactivity.</p> <ul style="list-style-type: none"> • In tests of aerobic capacity (1 mile run): 59.4% of 5th grade and 56.9% of 7th grade were in HFZ. • In Body Composition: 49.7% of 5th grade and 47.8% of 7th grade were in HFZ. <p>Of concern is percentage of students in Needs Improvement-High Risk zones:</p> <ul style="list-style-type: none"> • Aerobic capacity: 6.3% of 5th grade and 11.7% of 7th grade students • Body Composition (indicates student at risk for metabolic syndrome and indicator of current or future health risks): 34.9% of 5th grade and 37.0% of 7th grade were in High Risk zones. <p>In 2009-10, in a Healthy Kids Survey of 52% of RCSD 5th grade students (496</p>

	<p>students: 52% female and 48% male), ages 10 and 11 years old, reported:</p> <ul style="list-style-type: none"> • lifetime use of alcohol: 28% reported taking 1 or 2 sips of alcohol; 61% reported drinking was very bad for a persons health; 35% reported it was a little bad • lifetime and current use of cigarettes: 3% had smoked part of a cigarette (1-2 puffs) and 3% within past month; 90% reported cigarettes as very bad for a person’s health • breakfast consumption: 79% ate breakfast the morning of the survey • exercise, dance or play sports: 34% reported 6-7 days/week • body image: 10% think they are too skinny, 73% just right, 17% too fat • doing anything to lose weight: 47% no; 53% yes • teased by other kids at school about how you look? 69% no; 31% yes • students with asthma: told by an adult they have asthma, 84% no; 6% yes • have trouble breathing when not exercising: 83% no; 17% yes <p>According to the San Mateo County Asthma Profile, Lifetime Asthma Prevalence (California Health Interview Survey-CHIS) 2009: the percentage of children 5-17 years diagnosed in San Mateo County diagnosed with asthma by a health provider was 20.9%, which is higher than the 16.2% of children 5-17 years in CA.</p>
Program Description	<p>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 and Wellness Committee partners. The core feature of the program is special walking courses installed by Sequoia at every elementary school in Redwood City. Each bright orange walking course is measured and marked with signs indicating the number of laps needed to complete a mile. The signs also provide messages about the value of physical activity and encourage students to walk an additional lap each day. The courses are open for before- and after-school community programs and can be used by neighborhood families and older adults during evenings and on weekends. As part of MTF, fourth grade students complete workbooks with learning activities about key health messages and teachers are given Fit Fun guides to help them incorporate fun physical activities throughout the school day. In addition, the entire student body at each school joins in periodic lunch time events and some classes chart their progress toward physical activity goals. 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.</p>
FY 2012	
Goal FY 2012	<p>Empower school-aged children and their families in Redwood City and neighboring communities to recognize and adopt behaviors for lifelong good health. Utilize the existing environment of school campuses to promote physical activity and work with partners to provide nutrition and physical activity programs at schools.</p>
2012 Objective Measure/Indicator of Success	<p>Serve on School Wellness Committees in San Carlos, Redwood City, Sequoia Union High School Districts and Get Healthy San Mateo County Task Force Advisory Council.</p> <p>Lead implementation of Make Time for Fitness Spring Training for Health (at Taft, Fair Oaks, Hoover, Garfield, Hawes) and Annual MTF in Red Morton Park Fieldtrip for 4th grade students district-wide in May 2012.</p>

	<p>Review and update Make Time for Fitness Activity Book to reflect new nutrition “My Plate” guidelines and consider addressing the use of alcohol by utilizing Youth Asset Development messages.</p> <p>Provide a SF Giant Player and program for Garfield School in September 2011.</p> <p>Provide health presentations to RCSD parent groups in Sept–Dec 2011. Diabetes, nutrition, and vaccinations are identified topics of interest.</p> <p>Create an evaluation tool to measure the success of MTF activities in March–May 2012.</p>
Baseline	<p>The students and families in the Redwood City community schools have disproportionate unmet health needs. The MTF Spring Training for Health and Annual Fieldtrip for 4th grade in the RCSD have been selected as a goal of the RCSD Wellness Committee for 2011-12 school year.</p>
Intervention Strategy for Achieving Goal	<p>Utilize Sequoia Hospital’s bilingual student nurses in MTF program activities for RCSD students and parents.</p> <p>Engage Sequoia’s Live Well with Diabetes Health Promoters in teaching classes for groups within the RCSD North Fair Oaks community.</p> <p>Identify key activities for MTF fieldtrip educational program.</p> <p>Use expertise of community partners to create new messages for MTF Activity Book.</p> <p>Identify opportunities to participate in Nutrition Education for students and parents at community schools.</p>
Result FY 2012	<p>Director of Health & Wellness Center served on wellness committees for San Carlos, Redwood City Elementary and Sequoia Union High School Districts and Get Healthy San Mateo County Task Force Advisory Board.</p> <p>Spring Training for Health activities were implemented in collaboration with Power Play! at Garfield, Hoover, Taft and Fair Oaks Community Schools. Fourth grade teachers reported: “It has made a difference. My students are starting to look at labels of things they are eating and drinking. I noticed students are choosing more fruits and veggies during lunch”.</p> <p>Facilitated a SF Giant Player/Spanish Radio Broadcaster visit and program at Garfield School in September 2011 to kick off the school year.</p> <p>Wellness Committee members met, reviewed, and revised the MTF Activity Books for 4th grade. Alcohol use was not added.</p> <p>A survey was conducted by the RCSD Wellness Coordinator to determine the use of the Make Time for Fitness Walking Courses at each school. Use continues in ways that are unique to each campus. The RCSD Facilities Dept has done an excellent job of maintaining all of the courses.</p> <p>Health presentations were provided for RCSD parent groups during FY12. Professionals from Sequoia Hospital, student nurses and Diabetes Health</p>

	<p>Promoters addressed topics including Diabetes, Nutrition and Vaccinations.</p> <p>Make Time for Fitness Fieldtrip for 1,000 4th grade students from 14 RCSD schools was held May 16, 2012. Theme was "Eat Healthy, Stay Active, Be Tobacco Free". Interactive learning stations included farmer's market, yoga, sugar-free beverages, tobacco awareness, and friendship fitness. The Redwood City Parks and Recreation Afterschool program leaders led zumba and yoga. Carlmont High School Students Offering Support (SOS) Program led friendship fitness.</p> <p>Evaluations from teachers, community groups and leaders were excellent. Student learning was evaluated by an essay that noted recall of activities and key messages. A drawing was held for a bike and helmet.</p> <p>Sequoia Hospital's Pulmonary Rehabilitation Department has started an asthma education and management program in the Sequoia Union High School District schools. In spring 2012, initial training was provided for the physical education department and health aides.</p>
Hospital's Contribution / Program Expense	\$42,055
FY 2013	
Goal 2013	Empower school-aged children and their families in Redwood City and neighboring communities to recognize and adopt behaviors for lifelong good health. Utilize the existing environment of school campuses to promote physical activity and work with partners to provide nutrition and physical activity programs at schools.
2013 Objective Measure/Indicator of Success	<p>Redwood City School District:</p> <ul style="list-style-type: none"> • Lead implementation of Make Time for Fitness Program and annual MTF in Red Morton Park Fieldtrip for 4th grade district-wide in May 2013. • Respond to requests from RCSD schools for educational programs and support of events utilizing MTF Walking Courses. Utilize Sequoia Hospital's relationships with Student Nurses and Diabetes Health Educators. • Provide a SF Player Visit/Spanish Radio Announcer for Kennedy Middle School program on teamwork and leadership at start of the school year in September 2012. • Create a program at Hoover School to address "Plate Waste" with 200 students who are eligible for free lunch. Increase number of students who eat lunch in school cafeteria. <p>Sequoia Union High School District (SUHSD):</p> <ul style="list-style-type: none"> • Sequoia Hospital Pulmonary Rehabilitation Department will continue Asthma Education and Management Program. • Measurable goals and objectives will be established in September 2012.
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

	<p>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.</p>
Intervention Strategy for Achieving Goal	<p>Director of Health & Wellness will serve on Wellness Committees in SUHSD, RCSD, and San Carlos, and provide linkages to appropriate Sequoia Hospital staff to address identified needs.</p> <p>Utilize community partners to plan and implement MTF Spring Program for RCSD 4th grade.</p> <p>In September 2012, identify appropriate activities which utilize Sequoia Hospital competencies and resources and fit with the strategic plans created by the Wellness Coordinator and Wellness Committee for the 2012-13 school year.</p> <p>Meet with the SUHSD wellness coordinator regularly to identify the assessed needs of high school students which could be addressed by Sequoia Hospital. July 2012, areas for discussion include Diabetes Education for students, CPR Training for 9th grade students and SUHSD staff and management of concussions. We have been invited to participate in wellness programming for SUHSD employees.</p>
Community Benefit Category	<p>A1: Community Health Education F7: Community Building Activities</p>

Sequoia Hospital Homecoming Program (SHHP)	
Hospital CB Priority Areas	<input type="checkbox"/> Chronic Disease Prevention & Management <input checked="" type="checkbox"/> Healthy Aging in Place <input type="checkbox"/> Child/Youth Healthy Development <input type="checkbox"/> Community Building
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>According to the 2008 Community Needs Assessment: Currently, more than one out of three area seniors lives alone, and nearly one out of five lives below the 200% poverty threshold. Further, seniors in San Mateo County report much higher prevalence of debilitating chronic conditions, such as arthritis, diabetes, heart disease, high cholesterol, high blood pressure, and chronic lung disease.</p> <p>This priority area calls us to “prepare systematically for the demographic shifts in the population and accessibility of ‘aging in place’ by actively planning for the impacts of the increasing number of seniors in all services offered”.</p> <p>Patients with complex medical needs, primarily older patients, are at risk for poorer outcomes and are at much higher risk of readmission to the hospital within the first 30 days after discharge. Sequoia Hospital discharge planners, as well as our community partners, recognize the critical need for supportive services for isolated older adults with few resources who are discharged from the hospital.</p>
Program Description	<p>Sequoia Hospital Homecoming Program (SHHP) is a four-week hospital-to-home transitional care service provided through Dignity Health/ Sequoia Hospital Community Grants Program and a collaboration of not-for-profit agencies working together to bridge the gap between hospital and a strong recovery for older adults (age 50+) who reside in the Sequoia Healthcare District.</p> <p>Sequoia Hospital discharge planners/social workers identify those who could benefit from assistance with their hospital to home transition. SHHP is offered regardless of income. Clients are typically isolated, lack adequate support systems and resources and have other issues that place them at risk for readmission. A SHHP client referral form and medical information release agreement are completed prior to discharge.</p> <p>Upon discharge from the hospital, a bilingual case manager, MSW from Peninsula Family Service receives the client referral form and responds within 24 hours for a home visit and assessment. Assessment is made for food/nutrition, transportation, transition coaching and need for home safety modifications. Appropriate referrals to SHHP partners and community providers are made. Peninsula Volunteers - Meals on Wheels, delivers up to 7 hot nutritious meals on weekdays to client for up to 4 weeks. Samaritan House provides coaching and education with one house visit (within 48 hours) and three telephone meetings to promote recovery. This includes coaching on management of medication, awareness of red flags indicating a worsening condition, communication with physician and/or scheduling follow up appointments and creation of a personal health record. The SHHP collaborating partners provide a seamless continuum</p>

	<p>of care for newly discharged patients.</p> <p>At four weeks the case manager and Sequoia Hospital social worker team conduct care coordination to close the case or recommend on-going services to address further needs. Some partners are able to provide ongoing services for eligible clients while others are referred to appropriate community services.</p>
FY 2012	
Goal FY 2012	SHHP 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 SHHP strategy.
2012 Objective Measure/Indicator of Success	<p>SHHP client re-admission rates within 30 days of the initial hospital discharge will be tracked and will remain below 10%.</p> <p>Formal client evaluations will be conducted by December 2011.</p> <p>SHHP collaborative partners will meet quarterly to share successes and challenges and to make adjustments to the program.</p> <p>Partners who are no longer funded by Dignity Health/Sequoia Hospital Community Grants Program will continue to attend SHHP meetings and will collaborate and cross-refer to serve vulnerable older adults in our community. Services provided to SHHP clients will be documented.</p>
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.
Intervention Strategy for Achieving Goal	<p>Dignity Health/Sequoia Hospital Community Grants Program will provide funding support for SHHP. Grants will be awarded January 2012.</p> <p>Identify Transportation and Fall Prevention resources to be additions to SHHP services.</p> <p>Consider the role of home health/ home care services and communication with the primary care physician as they relate to SHHP.</p> <p>Client evaluations will be conducted and results utilized for program enhancements or modifications.</p> <p>Sustainability of program beyond Dignity Health/Sequoia Hospital Grant Funding will be addressed. The collaborative partners along with Sequoia Hospital staff will examine the potential of this program to be part of a larger comprehensive community continuing care program.</p>
Result FY 2012	<p>During FY12, SHHP received 76 referrals and 59 patients accepted and received services.</p> <p>SHHP client hospital readmission rates for FY12 were 5%.</p> <p>A formal client evaluation survey was created and piloted by SHHP partners and</p>

	<p>Applied Survey Research. Return from clients was limited and survey was determined to be too lengthy and detailed. Survey was revised and a plan for implementation has been created.</p> <p>In January 2012, four organizations were funded by Dignity Health/Sequoia Hospital Community Grants Program to participate in SHHP and contribute to promoting Healthy Aging in Place for older adults in our community. Peninsula Family Service, Peninsula Volunteers, Samaritan House, San Mateo County Fall Prevention Task Force received funding.</p> <p>SHHP partners met quarterly and communicated regularly as needed to serve clients.</p> <p>Partners who are no longer funded by Dignity Health/Sequoia Hospital Community Grants Program did not attend SHHP partner meetings, but continued to provide services that aligned with their organizations.</p>
Hospital's Contribution / Program Expense	Dignity Health/Sequoia Hospital Grants Program Funds: \$100,000 Health & Wellness/Social Services: \$37,908
FY 2013	
Goal 2013	SHHP 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 SHHP strategy. SHHP will be expanded to provide more referrals for Emergency Room patients and from local physician's offices.
2013 Objective Measure/Indicator of Success	<p>SHHP client re-admission rates within 30 days of initial hospital discharge will be tracked and will remain below 10%.</p> <p>Formal client evaluations of SHHP services will be conducted and reported in FY13. Goal will be a 50% return.</p> <p>SHHP collaborative partners will meet quarterly to share successes and challenges and to make adjustments to the program.</p> <p>Dignity Health/Sequoia Hospital Community Grants Program will provide funding support for SHHP. Grants will be awarded in January 2013.</p> <p>SHHP referrals and number served will be increased to 100 clients.</p> <p>The SHHP program will be introduced to local physician offices and appropriate referrals will be accepted.</p>
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.

<p>Intervention Strategy for Achieving Goal</p>	<p>Sequoia Hospital will create a Navigator position for SHHP to increase numbers of referrals throughout Sequoia Hospital in-patients and out-patients and begin communication with local physicians.</p> <p>Dignity Health /Sequoia Hospital Community Grants Program funding will match Sequoia Healthcare District Grant dollars for SHHP.</p> <p>Consider additional SHHP community partners to provide home care/private duty services.</p> <p>SHHP partners meet quarterly. Topics will include a presentation on the transition coaching model, a review of data collection and reporting criteria for SHHP stats and Client Evaluation.</p> <p>Develop a strategy for communicating with SHHP client's referring physicians.</p> <p>Understand when, who and why SHHP clients are readmitted to Sequoia Hospital before 30 days following discharge and compare with data for Sequoia Hospital patients who are not participants in SHHP.</p> <p>SHHP partner organizations and Sequoia Hospital staff serve on a Sequoia Community Continuing Care Program committee utilizing Sequoia Healthcare District "incubator funding" to consider a program which will be outside the walls of Sequoia Hospital and serve residents of the Sequoia Healthcare District. An IT system to provide connectivity among providers will be considered.</p>
<p>Community Benefit Category</p>	<p>H3: Health Care Support Services</p>

Fall Prevention	
Hospital CB Priority Areas	<input type="checkbox"/> Chronic Disease Prevention & Management <input checked="" type="checkbox"/> Healthy Aging in Place <input type="checkbox"/> Child/Youth Healthy Development <input type="checkbox"/> Community Building
Program Emphasis	<input type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input checked="" type="checkbox"/> Build Community Capacity <input checked="" type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>Falls are a key issue leading to hospitalization, loss of independence and death among seniors. They are the leading cause of unintentional injury death (77.6%) in San Mateo County among people 65 and older. In 2011, San Mateo County hospitals admitted and hospitalized 1,566 residents 65 years and older for falls. There were 53 deaths reported due to falls. In 2011, 213 individuals over age 65 years were hospitalized at Sequoia Hospital for a fall.</p>
Program Description	<p>The Fall Prevention Program includes a free, three-week course at the Sequoia Hospital Health & Wellness Center. 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.</p> <p>In 2003, Health & Wellness staff created the San Mateo County Fall Prevention Task Force, which brings together 30 organizations to create and disseminate fall prevention resources. The Task Force outreach and education focuses on primary prevention by encouraging older adults to address causes of falls through the use of evidenced-based interventions. The director of Health & Wellness serves on the Task Force Steering and Membership Committees. Active participation in the Fall Prevention Task Force is an effective way for Sequoia Hospital to contribute to addressing fall prevention throughout our primary service area.</p>
FY 2012	
Goal FY 2012	<p>Decrease the rate of falls among older adults in the community by increasing awareness of and action to address the factors that cause falls.</p>
2012 Objective Measure/Indicator of Success	<p>By June 2012, conduct five Fall Prevention courses.</p> <p>By June 2012, 75% of participants in the fall prevention course will self-report at least two behavior changes that decrease the risk of falls via phone interviews conducted three months after completion of the course.</p> <p>By June 2012, strengthen the continuum of care by conducting education and promotion of the Fall Prevention course with local physicians and Sequoia Hospital in-patient and ancillary care departments. Track referral sources of class participants and increase class attendance by 15%.</p> <p>Support the San Mateo County Fall Prevention Task Force with Dignity Health/Sequoia Hospital Community Grants 2011 Program funding and provide in-kind support for Task force activities to reach the broad and vulnerable</p>

	<p>communities.</p> <p>By January 2012, provide a Fall Prevention Program in English and Spanish for the Belle Haven Senior Center in Menlo Park.</p>
Baseline	<p>"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 Community Assessment Key Finding.</p>
Intervention Strategy for Achieving Goal	<p>Continue active participation on Steering and Membership Committees of San Mateo County Fall Prevention Task Force. Support Sequoia's fall prevention class instructors to attend task force meetings and trainings.</p> <p>Participate in county-wide Fall Prevention Week Campaign in September 2011.</p> <p>Provide physicians with information on Fall Prevention courses and activities utilizing the Professional Staff Newsletter and communicate directly to the Sequoia Medical Group.</p> <p>Inform Physicians when their patients have completed the Sequoia Hospital fall prevention course.</p> <p>Provide fall prevention materials for distribution to patients who have experienced a fall and seek treatment at the Sequoia Hospital Emergency Department.</p> <p>Provide ancillary departments of Sequoia Hospital with fall prevention resources for patients in English and Spanish.</p>
Result FY 2012	<p>During FY12, two fall prevention courses were conducted for 13 community members. 75% of course participants reported at least two sustained behavior changes based on follow-up phone interviews conducted six months after course completion.</p> <p>Sequoia Hospital Homecoming Program (SHHP) clients received fall prevention information.</p> <p>Dignity Health/Sequoia Hospital Community Grants awarded the San Mateo County Fall Prevention Task Force a grant in January 2012.</p> <p>All ancillary departments at Sequoia Hospital have materials in English and Spanish for patients identified with risk for falls. Materials are created and provided collaboratively by the San Mateo County Fall Prevention Task Force.</p> <p>The Belle Haven Senior Center is being served by Stanford Hospital programs for fall prevention.</p> <p>Sequoia Hospital director of Health & Wellness, fall prevention instructors, rehab therapists are all active participants in the San Mateo County Fall Prevention Task Force. Space for fall prevention meetings is provided by the Health & Wellness Center.</p> <p>Fall Prevention class schedules and information was provided monthly to Sequoia Hospital physicians via the Professional Bulletin. This vehicle was not successful in increasing referrals from physicians to Sequoia's fall prevention classes.</p>

Hospital's Contribution / Program Expense	Sequoia Hospital's Fall Prevention Course: 7,880 Staff time dedicated to San Mateo County Fall Prevention Task Force:5,128
FY 2013	
Goal 2013	Decrease the rate of falls among older adults in the community by increasing awareness of and action to address the factors that cause falls.
2013 Objective Measure/Indicator of Success	<p>Conduct fall prevention classes and increase attendance. Conduct follow-up calls to participants at three months post class to collect self-reported data on sustained behavior changes and incidence of falls.</p> <p>Collect hospital data on admissions for falls and visits to the emergency room for falls and without admission to the hospital.</p> <p>Collect data on SHHP clients' awareness of fall prevention as noted by coach and case manager.</p> <p>Survey fall prevention awareness at health screenings for older adults at senior centers. Utilize National Council on Aging Survey for Older Adults to measure changes across time and behaviors and attitudes regarding falls.</p>
Baseline	"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 Community Assessment Key Finding.
Intervention Strategy for Achieving Goal	<p>Active participation with San Mateo County Fall Prevention Task Force.</p> <p>Provide fall prevention information to Sequoia physicians in monthly professional staff newsletter. Provide an in-service for physicians and support staff at the Sequoia Medical Group.</p> <p>Provide fall prevention materials in English and Spanish to Sequoia Hospital's emergency and ancillary departments.</p> <p>Director of Health & Wellness Center will serve on Sequoia Hospital's Falls and Restraint Committee to enhance the continuum of care between those served at the hospital and the broad community.</p> <p>Invite the San Mateo County Fall Prevention Task Force to apply for Dignity Health/Sequoia Hospital Community Grants 2012 Program.</p> <p>Collaborate with Stanford Medical Center to bring an evidence-based, nationally recognized program, Matter of Balance, to southern San Mateo County.</p>
Community Benefit Category	A1: Community Health Education

Live Well with Diabetes	
Hospital CB Priority Areas	<ul style="list-style-type: none"> X Chronic Disease Prevention & Management <input type="checkbox"/> Healthy Aging in Place <input type="checkbox"/> Child/Youth Healthy Development <input type="checkbox"/> Community Building
Program Emphasis	<ul style="list-style-type: none"> 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	<p>Rates of diabetes among members of the community continue to rise. The 2008 Community Assessment shows that since 1998, there has been a statistically significant increase in the prevalence of diabetes among San Mateo County residents (from 3.9% in 1998 to 8.2% in 2008 and 9% projected in 2011). The 5-year moving average for diabetes mortality for the Hispanic population in San Mateo County 2004-2008 was 17.3 deaths per 100,000, compared to 9.7 for White and 12.3 for All Races.</p>
Program Description	<p>The Live Well with Diabetes program includes a five-session diabetes management and prevention course for people who are at high risk for diabetes or who have pre-diabetes or diabetes, and also their caregivers. The majority of courses are taught in Spanish by trained Diabetes Health Promoters (DHP's) most of whom were recruited through Cañada College's Promoter Education and Employment Project (PEEP). The program is implemented through collaboration between four agencies: Cañada College, Peninsula Family Service, Samaritan House Free Clinic in Redwood City and Sequoia Hospital Health & Wellness Center and the Diabetes Center at Sequoia Hospital.</p>
FY 2012	
Goal FY 2012	<p>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 by providing culturally competent nutrition, physical activity and diabetes management education.</p>
2012 Objective Measure/Indicator of Success	<p>By June 30, 2012, three DHP's will lead a minimum of ten Live Well with Diabetes courses reaching 120 community members in the Fair Oaks area of Redwood City (94063).</p> <p>By June 30, 2012, Live Well with Diabetes course participants will demonstrate a 25% increase in knowledge about diabetes prevention and management (based on pre- and post-tests).</p> <p>By June 30, 2012, 80% of Live Well with Diabetes course participants will report at least two sustained behavior changes (based on follow-up phone interviews conducted six months after course completion).</p> <p>By June 30, 2012, avoidance of hospital admissions and emergency department visits for diabetes among Live Well with Diabetes course participants (based on self reported data during the follow-up phone interview six months after course completion) will be demonstrated.</p>

Baseline	One diabetes education program exists in the community, but it has narrow eligibility requirements. The prevalence of diabetes among San Mateo County residents continues to increase.
Intervention Strategy for Achieving Goal	<p>Continue to develop the skills of Diabetes Health Promoters (DHPs) in the areas of nutrition, physical activity and diabetes management with additional training provided by a member of the Sequoia Hospital Diabetes Treatment Center staff in fall 2011.</p> <p>DHPs will review Live Well with Diabetes curriculum and make suggestions for revisions based on their teaching experience.</p> <p>Current tools used for presentations will be reviewed and updated, as necessary.</p> <p>Live Well with Diabetes curriculum will be reviewed by Sequoia Hospital Diabetes Treatment Center staff and recommendations for updates and changes will be made to the Advisory Committee and DHPs.</p> <p>Class observations followed by consultation with each DHP will be made during FY12.</p> <p>Encourage DHP's to conduct classes for parent groups within the Redwood City School District North Fair Oaks area.</p> <p>All class Pre-Post Tests and Evaluations will be reviewed by a member of the Advisory Committee and feedback will be given to the DHP who taught the class</p>
Result FY 2012	<p>Diabetes health promoters conducted 14 courses serving 154 participants.</p> <p>Pre-test scores averaged 64% and post-test scores averaged 81%.</p> <p>33 students were reached by a follow-up phone call 6 months after completion of the course. 88% (29 students) reported 2 sustained behavior changes. No hospital admissions or emergency room visits for diabetes were reported.</p> <p>Diabetes Treatment Center RN/CDE provided refresher training, review of curriculum and helped to update materials in English and Spanish.</p> <p>Class observations and written feedback were given to each DHP.</p> <p>A quarterly diabetes support group was re-started at Fair Oaks Intergenerational Activity Center by a DHP.</p> <p>Beyond Live Well with Diabetes classes, DHPs participated in community health fairs, gave presentations for classes at Cañada College, provided classes for parents with students in the Redwood City School District and mentored a Cañada College CO-OP student.</p>
Hospital's Contribution / Program Expense	\$21,535
FY 2013	
Goal 2013	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 by providing culturally competent nutrition, physical activity and diabetes management education. .

<p>2013 Objective Measure/Indicator of Success</p>	<p>By June 30, 2013 three DHP's will lead a minimum of ten Live Well with Diabetes courses reaching 120 community members in the Fair Oaks area of Redwood City (94063).</p> <p>50% of course participants will be contacted for 6 month follow-up calls.</p> <p>By June 2013, Live Well with Diabetes course participants will demonstrate a 25% increase in knowledge about diabetes prevention and management (based on pre-and post-tests).</p> <p>By June 30, 2013, 80% of Live Well with Diabetes course participants will report at least two sustained behavior changes (based on follow-up phone interviews conducted six months after course completion).</p> <p>By June 30, 2013, avoidance of hospital admissions and emergency department visits for diabetes among Live Well with Diabetes course participants will be demonstrated (based on self reported data during the follow-up phone interview six months after course completion).</p>
<p>Baseline</p>	<p>One diabetes education program exists in the community, but it has narrow eligibility requirements. The prevalence of diabetes among San Mateo County residents continues to increase.</p>
<p>Intervention Strategy for Achieving Goal</p>	<p>Recruit for Live Well with Diabetes Classes utilizing contacts from Cañada College programs, Samaritan House clinics, Redwood City School District and Fair Oaks Intergenerational Adult Activity Center.</p> <p>DHP's maintain relationship with Cañada College CO-OP Program and explore ways to collaborate with Cañada College.</p> <p>Quarterly diabetes support groups will be conducted at Fair Oaks Intergenerational Activity Center.</p> <p>The Live Well with Diabetes Steering Committee will meet quarterly.</p> <p>Funding opportunities to ensure sustainability of program will be identified.</p> <p>Strategies recommended by the Steering Committee for increasing the number of responses to the 6 month follow-up calls to collect self-reported data (collecting email addresses, instructor of class making calls, call from office phone vs. cell) will be implemented.</p> <p>Attendance at LWD classes will be encouraged by offering a drawing for a Glucometer in the final class. Glucometers will be provided by Sequoia Hospital Diabetes Center.</p>
<p>Community Benefit Category</p>	<p>A1: Community Health Education</p>

Adult Screenings & Vaccines	
Hospital CB Priority Areas	<input checked="" type="checkbox"/> Chronic Disease Prevention & Management <input type="checkbox"/> Healthy Aging in Place <input type="checkbox"/> Child/Youth Healthy Development <input type="checkbox"/> Community Building
Program Emphasis	<input checked="" type="checkbox"/> Disproportionate Unmet Health-Related Needs <input checked="" type="checkbox"/> Primary Prevention <input checked="" type="checkbox"/> Seamless Continuum of Care <input type="checkbox"/> Build Community Capacity <input type="checkbox"/> Collaborative Governance
Link to Community Needs Assessment	<p>According to the 2008 Community Needs Assessment: "85.3% of the San Mateo County (SMC) adults exhibit one or more risk factors for heart disease and stroke, marking an unfavorable increase in cardiovascular risk since the initial 1998 assessment".</p> <p>Heart disease and stroke death rates continue to decline, while reported prevalence of high blood pressure and high blood cholesterol continues to rise.</p> <p>The 2011 Assessment projected (32.3%) of SMC adults say they have been told more than once by a healthcare professional that they have high blood pressure. This prevalence has increased significantly in SMC since 1998 (18.1%). Similarly, the percent of SMC residents who have been told that their blood cholesterol level was high has risen from 1998 (18.2%) to 2011 projection (34%).</p>
Program Description	<p>In the Community: Adult Screenings & Vaccines program includes monthly blood pressure screenings at six senior centers in the community. The screenings include one-on-one education and referrals to physicians for individuals with abnormal blood pressure and low heart rates.</p> <p>Quarterly and annual services at centers include diabetes screenings, group presentations on health topics, medication review by a nurse, stroke awareness information, seasonal flu and pneumococcal vaccine clinics. Focus is on high-risk populations.</p> <p>At Sequoia Hospital's Health & Wellness Center: Bimonthly low or no cost health screening days are open to all community members. Screenings are for high cholesterol, hypertension, diabetes and obesity, and include counseling and routine monitoring.</p> <p>Adult vaccine offerings currently include Tdap, Flu & Pneumococcal. Shingles vaccinations will be a new service line in Sept/Oct 2012.</p>
FY 2012	
Goal FY 2012	<p>To prevent cardiovascular disease and stroke by identifying individuals with hypertension or those at high risk for hypertension.</p> <p>To decrease the risk of illness and death among adults by vaccinating and educating as many individuals as possible, particularly those at high risk.</p>
2012 Objective Measure/Indicator of Success	<p>Provide monthly blood pressure screenings and education at five community centers for 220 participants/quarter.</p> <p>Provide quarterly diabetes screenings at two Adult Community Centers.</p> <p>Provide low-cost health screenings to a minimum of 60 individuals at the Health & Wellness Center.</p>

	<p>Provide 200 low-cost immunizations for flu and pneumonia. Provide 300 immunizations for Tetanus, Diphtheria, and Pertussis.</p> <p>New: Offer 150 Tdap vaccinations for 7th & 8th grade students in the DUHN community to help families achieve compliance with the new state mandated requirements for Tdap vaccination for school age children.</p>
Baseline	<p>Senior Centers do not offer blood pressure screening services. Monthly screenings offer seniors a way to monitor their blood pressure, staying healthy thereby promoting healthy aging in place.</p> <p>There is an identified need for Tdap inoculation of adults in contact with infant children and 7th-8th grade students in Redwood City School District (RCSD).</p>
Intervention Strategy for Achieving Goal	<p>Conduct flu and pneumococcal vaccine clinics at the Health & Wellness Center beginning Oct 2011.</p> <p>Offer low cost screenings that include screening for high cholesterol, hypertension, diabetes, as well as counseling and routine monitoring at low or no cost.</p> <p>Offer the RCSD Community Schools a Tdap clinic for 7th & 8th grade students who are not vaccinated and in compliance with California Assembly Bill 354, which becomes effective 30 days after the start of the 2011-12 school year.</p> <p>Provide Tdap vaccinations for adults at the Health & Wellness Center bimonthly screening days.</p> <p>Provide Stroke Awareness Information and Medication Cards and monitor their use at monthly blood pressure screenings.</p>
Result FY 2012	<p>843 blood pressure screenings were provided (207 Screenings per quarter) at six centers in the community.</p> <p>Veteran's Memorial Adaptive Physical Education Center was added as a screening site in January 2012. This community group was added because of their vulnerability due to multiple chronic conditions and physical disabilities.</p> <p>Results:</p> <ul style="list-style-type: none"> • 252 older adults (33%) were hypertensive • 75 older adults (11%) were referred to a physician for hypertension and/or low heart rate • 303 older adults (27%) were counseled on cardiovascular risk reduction behaviors. <p>Quarterly diabetes screenings:</p> <ul style="list-style-type: none"> • Twin Pines Adult Community Center: 52 screened; 15 (34%) elevated • Fair Oaks Intergenerational Activity Center: 40 screened; 5 (8%) elevated • Veteran's Adaptive PE: 23 Screened; 7 (32%) elevated • An educational presentation on diabetes and counseling were provided at the Veteran's site. <p>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 translation.</p>

	<p>The Sequoia Hospital Health & Wellness Center provided:</p> <ul style="list-style-type: none"> • Low-cost health screenings for 36 adults • Flu vaccines for 98 • Pneumonia vaccines for 4 • Tdap vaccinations for 124 adults; 73 minors <p>The Sequoia Hospital Health & Wellness Center conducted two clinics for the San Mateo County Health System late in the season. The goal was to reduce the burden on the system by encouraging individuals to receive their vaccine from private providers or local pharmacies early in the season. The number utilizing our clinic dropped significantly from previous years (2011: 240 vaccines; 2012: 98 vaccines).</p> <p>Tdap Vaccines: Sequoia Hospital Health & Wellness Center conducted a bi-monthly clinic to address the statewide need to inoculate adults in response to the epidemic of whooping cough (pertussis). We enrolled in the State of California Tdap Expansion Project. This program allowed us to offer vaccinations at a discounted rate to serve the community. New parents, family and caregivers of infants were targeted. Ob/Gyn offices were informed of our service as well as Pediatrician's offices.</p> <p>We conducted vaccination clinics at Redwood City Schools (DUHN) to serve 73 minors and helped the school district achieve 100% compliance with the state mandated requirements for 7th and 8th grade students.</p>
Hospital's Contribution / Program Expense	Expenses: \$22,952 Offsetting income: \$750 Community Benefit: \$22,202
FY 2013	
Goal 2013	<p>To prevent cardiovascular disease and stroke by identifying individuals with hypertension or those at high risk for hypertension. Prevent diabetes by identifying individuals in the pre-diabetic phase. To improve health literacy and address health disparities in the DUHN community.</p> <p>To decrease the risk of illness and death among adults and to protect young infants and children by vaccinating and educating as many adult individuals as possible, particularly those at high risk.</p>
2013 Objective Measure/Indicator of Success	<p>Provide monthly blood pressure screenings and education at six community centers for 220 participants per quarter.</p> <p>Provide quarterly diabetes screenings and education at three adult community centers.</p> <p>Provide low-cost health screenings and classes to a minimum of 60 individuals at the Health & Wellness Center.</p> <p>Provide low-cost immunizations for flu, pneumococcal and Tdap for 125 adults per quarter.</p> <p>Offer 150 Tdap vaccinations for 7th and 8th grade students in the DUHN community to help families and school district achieve compliance with the state-mandated requirements for Tdap vaccination for school age children.</p>

Baseline	Senior Centers do not offer blood pressure or diabetes screening services. Monthly screenings give seniors a way to monitor their blood pressure and glucose to promote healthy aging in place. There is an identified need for Tdap inoculation of adults in contact with infants and 7th and 8th grade students in the Redwood City School District.
Intervention Strategy for Achieving Goal	<p>In July 2012, meet with each Senior/ 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.</p> <p>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.</p> <p>Conduct Flu and Pneumococcal Vaccine Clinics for the San Mateo County Health System at Sequoia Hospital Health & Wellness Center beginning in October 2012.</p> <p>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.</p> <p>Offer the RCSD Community Schools a Tdap clinic for 7th and 8th grade students who are not in compliance with the law after the start and at the end of the 2012-13 school year.</p> <p>Provide Tdap vaccinations for adults at the Sequoia Hospital Health & Wellness Center on bimonthly screening days.</p> <p>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.</p> <p>Plan new services for FY13: Adult shingles (Zostavax) vaccine to be offered on community screening days at the Health & Wellness Center.</p> <p>Expand Monthly Blood Pressure Screening Clinic Program to serve the Mid-Peninsula Housing at Belle Haven area of Menlo Park (DUHN).</p>
Community Benefit Category	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, 2015, 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 2012, Sequoia Hospital provided \$43,363,809 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.

9/26/2012
240 Sequoia Hospital
Complete Summary - Classified Including Non Community Benefit (Medicare)
For period from 7/1/2011 through 6/30/2012

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	Revenues
<u>Benefits for Vulnerable</u>						
Financial Assistance	1,283	1,551,547	0	1,551,547	0.7	0.6
Medicaid	5,549	10,942,676	4,300,805	6,641,871	3.0	2.7
Community Services						
Community Benefit Operations	0	77,793	0	77,793	0.0	0.0
Community Health Improvement Services	1,059	256,133	0	256,133	0.1	0.1
Financial and In-Kind Contributions	18	2,902,124	0	2,902,124	1.3	1.2
Subsidized Health Services	0	21,521	0	21,521	0.0	0.0
Totals for Community Services	1,077	3,257,571	0	3,257,571	1.5	1.3
Totals for Vulnerable	7,909	15,751,794	4,300,805	11,450,989	5.2	4.6
<u>Benefits for Broader Community</u>						
Community Services						
Community Building Activities	57	180,650	0	180,650	0.1	0.1
Community Health Improvement Services	12,657	284,410	15,805	268,605	0.1	0.1
Financial and In-Kind Contributions	3,422	149,173	0	149,173	0.1	0.1
Health Professions Education	130	2,009,732	176,967	1,832,765	0.8	0.7
Totals for Community Services	16,266	2,623,965	192,772	2,431,193	1.1	1.0
Totals for Broader Community	16,266	2,623,965	192,772	2,431,193	1.1	1.0
Totals - Community Benefit	24,175	18,375,759	4,493,577	13,882,182	6.3	5.6
Unpaid Cost of Medicare	30,832	91,863,881	62,382,254	29,481,627	13.4	11.9
Totals with Medicare	55,007	110,239,640	66,875,831	43,363,809	19.8	17.5
Totals Including Medicare	55,007	110,239,640	66,875,831	43,363,809	19.8	17.5

| The above costs are actual costs calculated using cost accounting 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 Community Benefit Report and Plan for FY11-12 has been posted and featured on the Sequoia Hospital Website <http://www.SequoiaHospital.org>. This will be done for the FY12-13 Report and Implementation Plan

The "Sequoia Insider," a weekly employee 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.

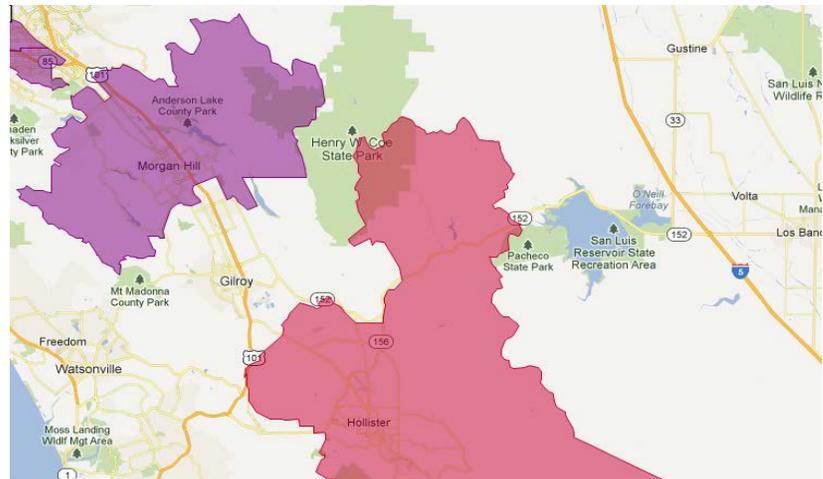
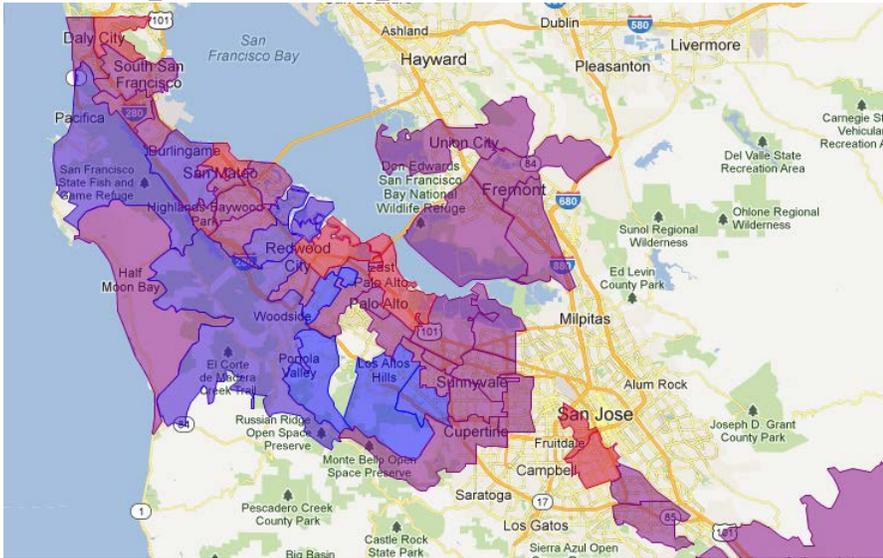
Sequoia uses social media platforms of Facebook and YouTube to promote and distribute this important information externally.

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

In March 2013, the 2013 Community Assessment: Health & Quality of Life in San Mateo County will be released. Sequoia Hospital, with Healthy Community Collaborative (HCC) partners, will participate in county-wide distribution of data.

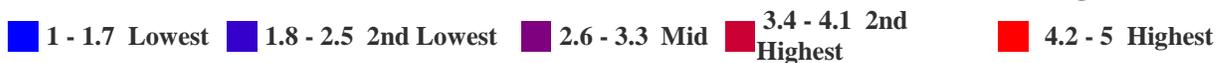
Attachment A

Sequoia Hospital



Lowest Need

Highest Need



Zip Code	CNI Score	Population	City	County	State
94002	2.6	25440	Belmont	San Mateo	California
94010	2.4	40422	Hillsborough	San Mateo	California
94014	3.6	48723	Daly City	San Mateo	California
94015	3	61385	Daly City	San Mateo	California

94019	3	20213	El Granada	San Mateo California
94022	1.6	18903	Los Altos	Santa Clara California
94024	1.6	22132	Loyola	Santa Clara 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
94030	3	21544	Millbrae	San Mateo California
94040	3.2	32678	Mountain View	Santa Clara California
94041	3.2	12913	Mountain View	Santa Clara California
94043	2.8	28707	Mountain View	Santa Clara California
94044	2.4	37979	Pacifica	San Mateo California
94061	3.2	34522	Redwood City	San Mateo California
94062	2.2	26976	Redwood City	San Mateo California
94063	4	32431	Redwood City	San Mateo California
94065	2.4	11768	Redwood City	San Mateo California
94066	3	40387	San Bruno	San Mateo California
94070	2.2	28382	San Carlos	San Mateo California
94080	3.2	64733	South San Francisco	San Mateo California
94086	2.8	43844	Sunnyvale	Santa Clara California
94087	2.8	50251	Sunnyvale	Santa Clara California
94089	3	18192	Sunnyvale	Santa Clara California
94301	2.6	16029	Palo Alto	Santa Clara California
94303	4	49190	Palo Alto	San Mateo California
94306	2.8	26261	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
94536	3.2	66919	Fremont	Alameda California
94538	3	59272	Fremont	Alameda California
94560	3.2	42668	Fremont	Alameda California
94587	3	76070	Union City	Alameda California
95014	2.6	58608	Cupertino	Santa Clara California
95023	3.8	49630	Hollister	San Benito California
95037	3.2	47209	San Jose	Santa Clara California
95051	3	54719	Santa Clara	Santa Clara California
95123	2.6	64137	San Jose	Santa Clara California
95125	3.6	50944	San Jose	Santa Clara California
95126	4	30553	San Jose	Santa Clara California
95136	2.8	42583	San Jose	Santa Clara California

CNI Median Score: 3.0

COMMUNITY ADVISORY COUNCIL ROSTER 2012

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* Indicates those members who also serve on Sequoia Hospital board of Directors.

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.