Sequoia Hospital

Community Benefit Report 2011
Community Benefit Plan 2012

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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 Catholic Healthcare West (CHW) in 1996 under a management agreement and became wholly owned by CHW in January 2008. The facility has 297 licensed beds and the Average Daily Census is 83 (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 square foot pavilion with expanded emergency services and larger, private patient rooms. Sequoia has a staff of 1,080 employees and professional relationships with more than 526 local physicians. Major Hospital services include a Heart and Vascular Institute, Birth Center, and Emergency Services.

During FY 2011 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 core service area. Sequoia Hospital's Community Benefit Plan for FY2012 will continue to support and enhance these initiatives that meet needs identified in the 2011 Community Needs Assessment. Priority areas are Chronic Disease Prevention and Management; Healthy Aging in Place; Child/Youth Healthy Development and Community Building.

Sequoia's Chronic Disease Prevention and Management Initiative is addressed by the Adult Screenings and Vaccines program, which includes monthly blood pressure screenings by a registered nurse at six senior centers. 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 selected diabetes as an ambulatory care sensitive condition requiring more specific focus. The prevalence of diabetes in the community was identified in the needs assessment process. The Hospital's Live Well with Diabetes Program, is a five-week, community-based diabetes self-management and prevention course. The class is the result of collaboration between Sequoia Hospital and three community agencies. In FY11, sixteen classes taught in English and Spanish by trained Diabetes Health Promoters reached 169 community members. During follow-up phone interviews six months after completion of the class, 45 students reported having no hospital admissions or emergency room visits for uncontrolled diabetes.

Healthy Aging in Place for older adults is addressed by the Sequoia Hospital Homecoming Program (SHHP), Fall Prevention classes and our 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 the Hospital and a strong recovery for older adults discharged from Sequoia. This program is supported by the CHW/Sequoia Hospital Community Grants Program. During March 2010-June 2011, 93 referrals were made to SHHP. Services were accepted by 61 patients. Our success is measured by a low 10.8% 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.

Our Make Time for Fitness School Programs, membership on school district Wellness Committees, and county-wide work with Get Healthy San Mateo County 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 broad community.

The Make Time for Fitness Program is a fun and educational, multi-faceted program that reinforces the theme of “Eat Healthy, Stay Active, Be Tobacco Free.”

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 common 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 FY 2011 Community Benefit Report and FY2012 Community Benefit Plan document our commitment to the health and improved quality of life in our community. The total amount quantified for Community Benefit in FY 11 is $47,059,396.

MISSION STATEMENT

Sequoia Hospital and Catholic Healthcare West 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.

All of our work is guided by a set of core values to which we hold ourselves accountable.
Our core Values are:

- **Dignity**-Respecting the inherent value and worth of each person.
- **Collaboration**-Working together with people who support common values and vision to achieve shared goals.
- **Justice**-Advocating for social change and acting in ways that promote respect for all persons and demonstrate compassion for our sisters and brothers who are powerless.
- **Stewardship**-Cultivating the resources entrusted to us to promote healing and wholeness.
- **Excellence**-Exceeding expectations through teamwork and innovation.

We seek to evaluate our performance in achieving our purpose by adopting standards that address our mission, values, spirituality, ethics and community health. We utilize local indicators to assess our progress in achieving these standards.

ORGANIZATIONAL COMMITMENT

Sequoia Hospital's Organizational Commitment

Developing and implementing the Community Benefit Plan are priorities of the Sequoia Hospital annual strategic plan. Sequoia Hospital's Board of Directors is responsible for approving the Community Benefit Plan and oversees its development and implementation through the Hospital's Community Advisory Council (CAC).

The CAC consists of 23 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 catalysts for relationship building and partnering with organizations, businesses, and individuals in the community. (Please see **Attachment B** for a roster of current Sequoia Hospital CAC members).

At the request of the Hospital's president, the vice president of Community Relations, president of the Sequoia Hospital Foundation and vice president of Physician and Business Development have administrative responsibility for the Community Benefit Plan. They 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 coordinates the Community Benefit 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, obesity specialists, CPR instructors and occupational therapists. Members of the Community Advisory Council (CAC) are advisors to the Health & Wellness staff.

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 CHW/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 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-chairing the Healthy Community Collaborative of San Mateo County, which oversees the triennial Community 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. Wellness Committees provide a forum for district leaders, staff, students, families, community organizations and individuals to collaborate on wellness efforts. She was a member of the Advisory Council of Get Healthy San Mateo County (GHSMC). GHSMC is a countywide collaborative of 300 community-based organizations, leaders, schools, afterschool programs, childcare centers, health care providers, cities and County staff which began in 2005. The GHSMC mission is to prevent childhood obesity by increasing access to healthy food and physical activity. The organization identifies the most prominent issues in battling the onset of overweight and obesity and implements solutions.

- Sequoia was a Community Partner in Redwood City 2020, which builds meaningful partnerships to support the success of children, youth and families and engages and strengthens the Redwood City school community.

- 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, Lee Michelson, served on the CHW/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/Administrator Glenna Vaskelis, 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. Ms. Vaskelis, 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, and American Heart Association, and others. Ms. Vaskelis has served on the Board of the Redwood City/San Mateo County Chamber of Commerce for 15 years and was Chair in 2009. In May, she served as Day Chair and Host of the Chamber of Commerce Leadership Redwood City, Belmont and San Carlos Program- Healthcare Leadership Day.

Sequoia Hospital's effort to protect the environment was an additional way we expressed our commitment to Community Benefit. In 2011, Sequoia received the national Environmental Leadership Circle Award 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 FY 2011, Sequoia donated 7,000 pounds of medical equipment and unused products to MedShare International.

COMMUNITY

Sequoia Hospital serves a Core Service Area comprised of suburban communities in Southern San Mateo County and Northern Santa Clara County: San Mateo, Burlingame, Half Moon Bay, Belmont, San Carlos, Redwood City, Menlo Park, Atherton, Portola Valley and Palo Alto. This area is defined by the Hospital's service area, geographic boundaries and historic Sequoia Healthcare District boundaries. The Core Service Area has a population estimated at 455,482 residents. The race/ethnicity distribution is White Non-Hispanic (53.1%); Black Non-Hispanic (3.12%); Hispanic (23.2%); Asian & Pacific Islander (16.6%); all others (4.0%). The median household income is $99,346, compared to the San Mateo County median income of $92,686. The population is well-insured with medical HMO and PPO coverage which has not changed significantly in the last 5 years. Distribution of coverage includes: MediCal (9.02%); Medicare (12.23%); Private Insurance (70.57%); and uninsured (8.18%),

The people residing in Sequoia Hospital's Core Service Area and the conditions influencing their lives vary enormously. While our area continues to be a wonderful place to live and work for the majority of its residents, some segments of our community experience hardship on a daily basis. A Key Finding of the 2011 Community Needs Assessment states "There are two San Mateo Counties: one for the economic 'haves' and one for the economic 'have nots.' The gap between these two is growing." The Community Need Index (CNI), a tool developed by CHW with Thomson-Reuters to measure community need in a geographic market, analyzes the degree to which a community faces barriers to health care access. The 2011 Community Assessment and the CNI identify four areas as the most vulnerable in Sequoia's core service area.

Zipcode	CITY	CNI	2010 Median Income	Ethnicity	Unemployment
(94063)	Redwood City	4	$ 59,308	69.2% Hispanic	8.9%
(94303)	North Palo Alto	4	$ 76,953	46.9% Hispanic	8.9%
(94401)	San Mateo	3.8	$ 67,249	38.7% Hispanic	5.8%
(94061)	Redwood City	3.2	$ 75,603	34.4% Hispanic	4.6%

By the year 2030, the number of adults over age 65 in San Mateo County 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. Increased rates of chronic diseases and cognitive impairments will result in a dramatic increase in demand for health care and community-based services. Compared to past generations, seniors in San Mateo County report a much higher prevalence of debilitating chronic conditions, such as arthritis, diabetes, heart disease, high cholesterol, high blood pressure and chronic lung disease.

Other hospitals that serve Sequoia Hospital's Core Service Area are Mills-Peninsula Medical Center; Lucile Salter Packard Children's Hospital at Stanford; Stanford Hospital; Kaiser Permanente Hospitals in Redwood City and Santa Clara; San Mateo Medical Center; California Pacific Medical Center-Pacific Campus and UCSF Medical Center.

Sequoia Hospital's community benefit activities focus on Redwood City (94063) and (94061) since these are the communities with disproportionate unmet health needs (DUHN) that surround our hospital geographically. San Mateo (94401) is served by Mills-Peninsula Medical Center and Kaiser Permanente. North Palo Alto (94303) is served by Stanford Hospital, Lucile Salter Packard Children's Hospital and Kaiser Permanente. Sequoia Hospital, Mills-Peninsula Medical Center, Kaiser Permanente, Stanford and Lucile Packard Hospitals promote collaborative efforts for county-wide initiatives and develop collaborative projects based on the data, community input and group consensus.

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

COMMUNITY BENEFIT PLANNING PROCESS

A. Community 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 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; Kaiser Foundation Hospital/Health Plan.

The HCC has overseen the triennial Community 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:

- To produce a functional, comprehensive community needs assessment that can be used for strategic planning of community programs and as a guideline for policy and advocacy efforts.
- To 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, 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 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 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 health care services.

- Falls are a key issue leading to hospitalization, loss of independence, and death among seniors. More resources should be directed toward this preventable occurrence.

- Heart disease and stroke death rates continue to decline, while reported prevalence of high blood pressure and high blood cholesterol continues to rise.

- 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 health care and community-based services.

Sequoia Hospital also utilizes the Community Need Index (CNI), a tool developed by CHW with Thomson-Reuters to measure community need in a geographic market, to analyze the degree to which a community faces barriers to health care access. The factors analyzed in the CNI are income, education, culture, insurance and housing. Based on statistical modeling, the combination of these factors results in a score ranking from one (less needy) to five (most needy). Four communities in Sequoia Hospital’s core service area were identified as “in need.” These are (94063) Redwood City (CNI 4); (94303) North Palo Alto (CNI 4); (94061) Redwood City (CNI 3.2); and (94401) San Mateo (CNI 3.8). See **Attachment A** for Sequoia’s CNI map and scores by zip code.

The 2011 Community Assessment of the San Mateo County Community (full report and all previous reports) are 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. Presenters have included: The 211 Community Information and Referral services for San Mateo County, Edgewood Center’s Kinship Program, San Mateo Health System Senior Planning, San Mateo County Fall Prevention Taskforce, Get Healthy San Mateo County, School Wellness Committees, Stanford Employee Wellness. The Sequoia Healthcare District has conducted Asset Assessments in Belmont, San Carlos, Redwood City (Community Schools) School Districts and Sequoia Union High School Districts, which inform Sequoia Hospital school program initiatives. 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 Plan)

The process that Sequoia Hospital utilizes to prioritize our community benefit activities is a dynamic one that 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. 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 our belief 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 an 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 FY12:

- **Preventing and/or Managing Health Conditions**:
  Blood Pressure, Diabetes and Cholesterol Screenings and Education at five Senior and Community Centers
  Adult Immunization Clinics for Influenza, Pneumonia, Tetanus, Diptheria, Pertussus
  Spanish language Live Well with Diabetes Classes
  Smoking Cessation Classes
  New: Eating for Health at St. Anthony's Padua Dining Room (94063 Redwood City).

- **Healthy Aging in Place:**
  Sequoia Hospital Homecoming Program (SHHP)
  CHW/Sequoia Hospital Community Grants Program for non-profit organizations
  Sequoia Hospital's Fall Prevention Classes and San Mateo County Fall Prevention Task Force

- **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
  New: Tdap Vaccine Clinics for school age children.

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

- **Improving Access to Health Care:**
  Charity Care for uninsured/underinsured and low income residents
  Health Professionals Education
  Emergency Department Physician Services for Indigent Patients.

- **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 Activate America/Pioneering Healthy Communities member
  Cañada College Human Services Advisory Board
  San Mateo County Breastfeeding Advisory Committee
  ACTive Communities Together Collaboration
  Sequoia Healthcare District Community Grants Review Committee member
  Redwood City 2020 Community Partner

It is our intention that programs 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) with 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 CHW Patient Financial Assistance Policy, which was updated in 2008 and is summarized below. A copy of the Summary of Patient Financial Assistance Policy can be found in **Attachment C**.

Policy Overview
CHW is committed to providing financial assistance to persons who have health care 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 situation. Consistent with its mission to deliver compassionate, high quality, affordable health care services and to advocate for those who are poor and disenfranchised, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them for seeking or receiving care. Financial assistance is not considered a substitute for personal responsibility. Patients are expected to cooperate with CHW's procedures for obtaining financial assistance and to contribute to the cost of their care based on their 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, and Patient Financial Services and Cashier 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, CHW has announced the policy widely in local newspapers. Sequoia Hospital has made the policy available on its website. 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 they can 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 FY 2011. Programs intended to be operated in 2012 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 a 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*

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*
CHW/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*

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 and capacity builder, and participating in communitywide 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 member*
- Peninsula Family YMCA Activate America/Pioneering Healthy Communities Committee member*
- Cañada College Human Services Advisory Board*
- San Mateo County Breastfeeding Advisory Committee*
- ACTive Communities Together Collaborative*
- Sequoia Healthcare District Community Grants Review Committee member*
- 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 supports many other ongoing Community Benefit activities that address critical health needs in our community.

The Hospital provides patients at Samaritan House Free clinic with free lab, radiology and other outpatient services. In FY2011, Sequoia provided $378,499 in free services for 1783 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, Parents of Multiples Support Group, Smoking Cessation Program, Food Addicts Anonymous, Neuropathy, For Those in Pain, American Cancer Society's Look Good Feel Better Program, Pathways Grief Support Group, Prostate Cancer Information Forum, Nursing Mothers Counsel and Hope House. The Health & Wellness Center's free meeting space served 2,477 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 3,774 individuals with breastfeeding support services valued at more than $144,679. Lactation staff also facilitate the New Parents Support Group offered at the Health & Wellness Center. This past year, 1,614 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 FY2011, 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 9,807 hours valued at $1,125,651 were dedicated to the direct training of 156 individuals across these health professions.

These activities are just a few of the ongoing projects that bring considerable value to our local community, as they further Sequoia’s commitment to Community Benefit. FY 2012 promises to offer more opportunities to explore Community Benefit programming that aligns with Sequoia’s priority areas.

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

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 and Catholic Healthcare West receive quarterly updates on program performance and news.

PROGRAM DIGEST

<table>
<tr><th colspan="2">Make Time for Fitness</th></tr>
<tr><td>Hospital CB Priority Areas</td><td>❑ Chronic Disease Prevention & Management
❑ Healthy Aging in Place
X Child/Youth Healthy Development
X Community Building</td></tr>
<tr><td>Program Emphasis</td><td>X Disproportionate Unmet Health-Related Needs
X Primary Prevention
❑ Seamless Continuum of Care
X Build Community Capacity
X Collaborative Governance</td></tr>
<tr><td>Link to Community Needs Assessment</td><td>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.

In 2009, 41.3% of San Mateo County 7th graders met basic fitness requirements, as determined by the California Department of Education.
In 2010, 22% of RCSD 7th graders met all fitness standards for their grade level.

38% of RCSD 5th graders are overweight/obese or at risk of becoming overweight or obese.

2009-10 enrollment in Redwood City School District’s (RCSD) 16 schools was 9,037 K-8th students.
70.4% are Hispanic/Latino; 21.3% White. 50.4% are English Learners; 62.9% qualify for free or reduced price meals (this rate was 47% in 2000).

Community Schools (Fair Oaks, Hoover, Kennedy, Taft) have student and family populations that are among those with the highest need in the district. They all have a very high percentage of students who qualify for Free or Reduced Price Lunch: Fair Oaks (93%), Hoover (90%), and Taft (90%).

According to 2009-10 Healthy Kids Survey, 61% of RCSD 5th graders believed alcohol is “very bad for a person’s health” and 90% said the same about cigarettes. 44% of 7th graders reported that occasional alcohol use posed a moderate (20%) or great (28%) risk of harm. 7th graders reported more potential harm from cigarettes than alcohol, with 90% reporting that smoking is very bad for a person’s health. 27% of RCSD 7th graders reported consuming alcohol at least once, and 8% have consumed it 4 or more times.</td></tr>
<tr><td>Program Description</td><td>Make Time for Fitness (MTF) encourages healthy eating, physical activity 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</td></tr>
</table>

	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 culminated 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.
FY 2011	
Goal FY 2011	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.
2011 Objective Measure/Indicator of Success	Aid the implementation and use of the FitFun Game Guide with $2,000 of financial and in-kind support. Lead implementation of Make Time for Fitness (MTF) activities at four RCSD elementary schools in March through May 2011, reaching 3,500 students. Coordinate with RCSD Wellness Committee and community partners to provide MTF program activities and culminating fieldtrip for 1,000 fourth grade students. Provide $20,000 of in-kind and direct support for the fieldtrip. Demonstrate positive impact of MTF program (evaluation measures TBD). Provide $2,500 of direct support for continuation of Mileage Clubs and start-up of new clubs. Participate on school district wellness committees and Get Healthy San Mateo County Task Force.
Baseline	All elementary schools in Redwood City now have MTF walking courses on their school campuses. Also, courses were installed at a city park in Redwood City and San Carlos.
Intervention Strategy for Achieving Goal	Enhance the evaluation component of MTF program activities to enable a better and more rigorous understanding of the program's impact. Utilize Sequoia Hospital's student nurses in MTF program activities for RCSD students and parents. Establish partnerships with RCSD Wellness Coordinator and the Sequoia Healthcare District Coordinated School Health Initiative.
Result FY 2011	"What we know is that when we look at physical fitness scores and test scores, we see a strong correlation. When the physical fitness scores of Redwood City students went up, their test scores went up. Conversely, when physical fitness scores went down, test scores went down. We saw this even when controlling for a variety of demographic factors. Programs that encourage physical fitness, like Make Time for Fitness, can make a big difference for kids--not just in their health but in their academic success. RCSD is grateful for partners like Sequoia Hospital that help make that possible!" Shelly Masur, Member -RCSD Board of

	Trustees. A SF Giant Baseball Player visit and program stressing the importance of walking and promoting International Walk to School Day was provided to John Gill School in September 2010. Donated $2,000 to the Redwood City Education Foundation to be used for continued implementation of the FitFun Game Guide by classroom teachers. Led the implementation of Spring Training for Health at five RCSD community schools reaching 3,500 students. Coordinated the annual MTF event in Red Morton Park on May 18, 2011, for 1,000 4th grade students. Both projects resulted from the successful collaboration of RCSD Wellness Committee members and community partners. Pre- and post- event quizzes were given to 4th and 5th grade students. The 5th graders demonstrated retention of knowledge from the previous year's MTF program with higher scores on the pre-test than the 4th graders. The 4th graders' post-event quiz scores were higher than their pre-event quiz scores. Program evaluations were conducted with 4th grade teachers and Activity Leaders at the MTF event, indicating satisfaction with program. Mileage Clubs were not consistent at schools due to lack of staff and parent leadership and an abundance of rain. Financial support was not sought by schools. Director of Health & Wellness served on School Wellness Committees in San Carlos, Redwood City and Sequoia Union High School Districts and on the Get Healthy San Mateo County Task Force Advisory Council. Sequoia Hospital was a Redwood City 2020 Community Partner. Sequoia re-stripped the Make Time for Fitness Course in Burton Park, San Carlos. The course is utilized by community members (youth through seniors) on a daily basis.
Hospital's Contribution / Program Expense	$41,223.00
FY 2012	
Goal 2012	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.
2012 Objective Measure/Indicator of Success	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. Lead implementation of Make Time for Fitness Spring Training for Health at Taft, Fair Oaks, Hoover, Garfield, Hawes Schools and the Annual MTF in Red Morton Park Fieldtrip for 4th graders district-wide in May 2012. Review and update Make Time for Fitness Activity Book to reflect new "My Plate" nutrition guidelines and consider addressing the use of alcohol by utilizing Youth Asset Development messages.

	Provide a SF Giant Player and program for Garfield School in September 2011. Provide health presentations to RCSD parent groups in Sept – Dec 2011. Diabetes, Nutrition, and Vaccinations are identified topics of interest. Create an evaluation tool to measure the success of MTF activities in March-May 2012.
Baseline	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 graders in the RCSD have been selected as goals of the RCSD Wellness Committee for 2011-12 school year.
Intervention Strategy for Achieving Goal	Utilize Sequoia Hospital's bilingual student nurses in MTF program activities for RCSD students and parents. Engage Sequoia's Live Well with Diabetes Health Promoters in teaching classes for groups within the RCSD North Fair Oaks community. Identify key activities for MTF fieldtrip educational program. Use expertise of community partners to create new messages for MTF Activity Book. Identify opportunities to participate in Nutrition Education for students and parents at community schools.
Community Benefit Category	A1: Community Health Education F7: Community Building Activities

Sequoia Hospital Homecoming Program (SHHP)	
Hospital CB Priority Areas	❑ Chronic Disease Prevention & Management X Healthy Aging in Place ❑ Child/Youth Healthy Development ❑ Community Building
Program Emphasis	X Disproportionate Unmet Health-Related Needs ❑ Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	According to the 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. 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". 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 when they are discharged from the hospital.
Program Description	Sequoia Hospital Homecoming Program (SHHP) is a hospital-to-home transitional care service provided through CHW/Sequoia Hospital Community Grants Program and a collaboration of not-for-profit agencies working together to bridge the gap between the Hospital and a strong recovery for older adults discharged from Sequoia Hospital. SHHP is intended to promote the successful recuperation of older adults after they return home from the hospital. SHHP serves older adults age 50 and over identified by Sequoia Hospital discharge planning staff as needing additional support to achieve a safe transition to home. 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. Upon discharge from the Hospital, the patient is assigned a bilingual (Spanish-English) case manager who conducts an assessment and home visit within 24 hours of referral. The case manager coordinates with the partner agencies to provide needed services (such as case management, transportation referrals, home-delivered meals, and self-care management skills training, as well as help with home repairs, housing needs and weekly grocery deliveries) for each client. The SHHP collaborating partners provide a seamless continuum of care for newly discharged patients.
FY 2011	
Goal FY 2011	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.
2011 Objective Measure/Indicator of Success	Fund five community agencies to collaborate in providing supportive services to 75 Sequoia Hospital patients after discharge. Demonstrate a reduction in the re-admission rate among SHHP participants (compared to a similar patient population). Expand SHHP services to include a bedside visit from a transitional care coach or case manager before discharge.
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	CHW/ Sequoia Hospital Community Grants Program subsidized the pilot program.
Result FY 2011	CHW/Sequoia Hospital Community Grants Program Funded five community agencies to continue to collaborate to provide SHHP. Agencies: Peninsula Family Service, Peninsula Volunteers, Samaritan House, Second Harvest Food Bank, Rebuilding Together Peninsula. Clients of SHHP are informally reporting positive experiences with the services provided. A comprehensive client assessment of the individual services provided through SHHP is being developed. SHHP has built community capacity as partners have continued to serve some clients after discharge from SHHP. Community agencies have learned what other services are available to their own clients and report making cross referrals. A Logic Model and system for reporting on referral and readmission rates was created. The pilot program began in March 2010. March 2010 – June 2011 (15 months) 93 Referrals made to SHHP 61 (65.8%) accepted services 10 (10.8%) readmissions within 30 days
Hospital's Contribution / Program Expense	CHW/Sequoia Hospital Grants Program Funds: $100,000 Health & Wellness staff: $1,771 In-kind Staff (Social Services) $12,844
FY 2012	
Goal 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	SHHP client re-admission rates within 30 days of the initial Hospital discharge will be tracked and will remain below 10%.

	Formal client evaluations will be conducted by December 2011. SHHP collaborative partners will meet quarterly to share successes and challenges and to make adjustments to the program. Partners who are no longer funded by CHW/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.
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	CHW/Sequoia Hospital Community Grants Program will provide funding support for SHHP. Grants will be awarded January 2012. Identify Transportation and Fall Prevention resources to be added to SHHP services. Consider the role of home health services and communication with the primary care physician as they relate to SHHP. Client evaluations will be conducted and results utilized for program enhancements or modifications. Sustainability of the program beyond CHW/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 health care reform plan.
Community Benefit Category	A3: Health Care Support Services

Fall Prevention	
Hospital CB Priority Areas	❑ Chronic Disease Prevention & Management X Healthy Aging in Place ❑ Child/Youth Healthy Development ❑ Community Building
Program Emphasis	❑ 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	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 2010, there were 5,526 San Mateo County residents over 65 who fell and required emergency medical care and/or hospitalization. This means 6% of the over-65 population required medical intervention for a fall. In 2010, 748 individuals over 65 were treated at Sequoia Hospital for a fall.
Program Description	The Fall Prevention Program includes a five-week course offered free of charge. Course curriculum is evidence-based and addresses the many factors affecting falls. Each course is taught by trained health professionals and includes simple exercise to improve strength and balance. In 2006, 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 Director of Health & Wellness serves on the Task Force Steering and Membership Committees.
FY 2011	
Goal FY 2011	Decrease the rate of falls among older adults in the community by increasing awareness of and action to address the factors that cause falls.
2011 Objective Measure/Indicator of Success	Strengthen the continuum of care by conducting education and promotion of the fall prevention program with local physicians and Sequoia Hospital inpatient departments. Train two new instructors and one community volunteer to teach the Fall Prevention course. Hold at least four Fall Prevention courses during FY2011, with at least two taking place at community sites. By June 2011, 75% of participants in the Fall Prevention program will report at least two behavior changes that decrease the risk of falls.
Baseline	Very few resources exist in our community to offer fall prevention education. One other fall prevention program is offered by Stanford Hospital, but it is one-on-one and participants must meet eligibility criteria.

Intervention Strategy for Achieving Goal	Provide physicians with patient education materials for their offices. Participate in county-wide Fall Prevention Week Campaign. Include information on Fall Prevention Courses in the Sequoia Hospital Professional Staff Newsletter. Encourage physician referrals to Sequoia Hospital's Fall Prevention Courses at Health & Wellness. Track referrals. One-on-one and observational training for new course instructors. Work with Rehabilitation Services staff so they will offer materials created for the community Fall Prevention course to Sequoia Hospital's inpatients identified as being at-risk for falling.
Result FY 2011	During FY2011, 4 Health Educators led five Fall Prevention courses that reached 88 community members. In FY 2011, 84% of Fall Prevention course participants reported at least two sustained behavior changes based on 25 follow-up phone interviews conducted six months after course completion. During FY2011, two new instructors and one community volunteer were trained to teach the Fall Prevention course. In September 2010, Sequoia Hospital participated in the county-wide Fall Prevention Week Campaign conducted by the San Mateo County Fall Prevention Task Force. This included a presentation to the San Mateo County Board of Supervisors and a Proclamation. During FY 2011, Sequoia Hospital Fall Prevention course announcements were posted on the San Mateo County Fall Prevention Task Force and Sequoia Hospital websites and Facebook. Announcements were also included in the Sequoia Hospital Professional Staff Newsletter. Flyers promoting the course were sent to Sequoia Hospital Ancillary Departments, Health & Wellness Center support groups, members of the faith community, senior/adult centers and community centers. 1% of referrals were from physicians.
Hospital's Contribution / Program Expense	$13,530.00 Sequoia Hospital's Fall Prevention Course $3,812.00 Staff time dedicated to San Mateo County Fall Prevention Task Force
FY 2012	
Goal 2012	Decrease the rate of falls among older adults in the community by increasing awareness of and action to address the factors that cause falls.
2012 Objective Measure/Indicator of Success	By June 2012, conduct five Fall Prevention courses. 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. 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%. Support the San Mateo County Fall Prevention Task Force with CHW/Sequoia Community Grants 2011 Program funding, and provide in-kind support for Task Force activities to reach the broad and vulnerable communities. By January 2012, provide a Fall Prevention Program in English and Spanish for the Belle Haven Senior Center in Menlo Park.
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	Continue active participation on Steering and Membership Committees of San Mateo County Fall Prevention Task Force. Support attendance of Sequoia's Fall Prevention class instructors. Participate in county-wide Fall Prevention Week Campaign in September 2011. Provide physicians with information on Fall Prevention courses and activities utilizing the Professional Staff Newsletter, and communicate directly with the Sequoia Medical Group. Inform Physicians when their patients have completed the Sequoia Hospital Fall Prevention course. Provide Fall Prevention materials for distribution to patients who seek treatment at the Sequoia Hospital Emergency Department after a fall. Provide Ancillary Departments of Sequoia Hospital with Fall Prevention Resources in English and Spanish for their patients.
Community Benefit Category	A1: Community Health Education

Live Well with Diabetes	
Hospital CB Priority Areas	X Chronic Disease Prevention & Management ❑ Healthy Aging in Place ❑ Child/Youth Healthy Development ❑ Community Building
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care X Build Community Capacity X Collaborative Governance
Link to Community Needs Assessment	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).
Program Description	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, as well as 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 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.
FY 2011	
Goal FY 2011	To help prevent and reduce the incidence of diabetes and prevent complications of diabetes among people in the underserved Latino community.
2011 Objective Measure/Indicator of Success	Five DHP's will lead a minimum of ten Live Well with Diabetes courses, reaching 120 community members by June 30, 2011. By June 30, 2011 Live Well with Diabetes course participants will demonstrate a 30% increase in knowledge about diabetes prevention and management (based on pre- and post-tests). By June 30, 2011 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). Demonstrate avoidance of hospital admissions and emergency department visits for diabetes treatment among Live Well with Diabetes course participants (based on self-reported data during the follow-up phone interview six months after course completion).
Baseline	One diabetes education program exists in the community, but it has narrow eligibility requirements. In FY 2006, Sequoia created and successfully piloted this program.
Intervention Strategy for Achieving Goal	Offer additional training for Diabetes Health Promoters (DHP).

	Administer pre- and post-tests, personal objective worksheets and follow-up phone interviews with all participants.
Result FY 2011	During FY2011, 5 DHPs led sixteen Live Well with Diabetes courses that reached 169 community members. DHPs participated at Saint Francis Center Family Day, Annual Hispanic Middlefield Road Fair, San Mateo County Streets Alive at Garfield School, and the Salvation Army Food Program. In FY2011, Live Well with Diabetes course participants demonstrated an 18% increase in knowledge about diabetes prevention and management based on pre- and post-tests. In FY 2011, 73% of Live Well with Diabetes course participants reported at least two sustained behavior changes based on 45 follow-up phone interviews conducted six months after course completion. During FY 2011, no (0%) Live Well with Diabetes participants were admitted to a hospital or had an Emergency Room visit for uncontrolled diabetes based on self-reported data during the 45 follow-up phone interviews conducted six months after course completion.
Hospital's Contribution / Program Expense	$10,725.00
FY 2012	
Goal 2012	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. .
2012 Objective Measure/Indicator of Success	By June 30, 2012 three DHPs will lead a minimum of ten Live Well with Diabetes courses, reaching 120 community members with emphasis on those who are vulnerable. 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). 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). By June 30, 2012, avoidance of hospital admissions and emergency department visits for uncontrolled 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).
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	Continue to develop the skills of health promoters 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. DHPs will review Live Well with Diabetes curriculum and make suggestions for revisions based on their teaching experience. Current tools used for presentations will be reviewed and updated, as necessary. 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. Class observations followed by consultation with each DHP will be made during FY12. Encourage DHPs to conduct classes for parent groups within the Redwood City School District North Fair Oaks area. All class pre- and 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.
Community Benefit Category	A1: Community Health Education

Adult Screenings & Vaccines	
Hospital CB Priority Areas	X Chronic Disease Prevention & Management ❑ Healthy Aging in Place ❑ Child/Youth Healthy Development ❑ Community Building
Program Emphasis	X Disproportionate Unmet Health-Related Needs X Primary Prevention X Seamless Continuum of Care ❑ Build Community Capacity ❑ Collaborative Governance
Link to Community Needs Assessment	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." Heart disease and stroke death rates continue to decline, while reported prevalence of high blood pressure and high blood cholesterol continues to rise. The 2011 Assessment projected (32.3%) of SMC adults say they have been told more than once by a health care 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 their blood cholesterol level are high has risen since 1998 (18.2%) to the 2011 projection (34%).
Program Description	Adult Screenings & Vaccines program includes monthly blood pressure screenings at five 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. Quarterly and annual services piggy-back on the monthly blood pressure screenings to offer diabetes screenings, group presentations on various health topics, medication review by a nurse, stroke awareness information, seasonal flu and pneumococcal vaccine clinics. Focus is on high-risk populations. As part of the Adult Screenings & Vaccines program, Sequoia participates in the county-wide Hep B Free Coalition. Sequoia's Health & Wellness Center provides low-cost health screenings open to all community members. This includes screening for high cholesterol, hypertension, diabetes and obesity, as well as counseling and routine monitoring at low or no cost.
FY 2011	
Goal FY 2011	To prevent cardiovascular disease and stroke by identifying individuals with hypertension or those at high risk for hypertension. To decrease the risk of illness and death among adults by vaccinating and educating as many individuals as possible, particularly those at high risk.
2011 Objective Measure/Indicator of Success	By March 1, 2011, offer flu vaccine to 300 individuals. Include a medication reconciliation component with the flu vaccine service. Provide blood pressure screenings and education to an average of 240 participants per quarter.

	Provide quarterly diabetes screenings and education at a minimum of one local senior center. Pilot a medication management project with a least 100 older adults at a local senior center. Provide low-cost health screenings to 60 individuals at the Health & Wellness Center. Monitor progress and report on behavior changes and use of medications that affect risk levels. As a county site for the Hep B Free coalition, provide Hep B vaccine to 50 individuals in FY2011.
Baseline	Senior Centers do not offer blood pressure screening services. Monthly screenings offer seniors a way to monitor their blood pressure and stay healthy, thereby promoting healthy aging in place. In 2011, the need for Tdap inoculation of adults in contact with infant children was identified. There are no clinics in the area.
Intervention Strategy for Achieving Goal	Conduct flu vaccine clinics at the Health & Wellness Center for all community members and at the Redwood City School District Office for teachers and school district staff. Identify venues for medication review program. Give HepB vaccines at the Health & Wellness Center and participate in regular Hep B Free coalition meetings. Offer low cost screenings for high cholesterol, hypertension, diabetes and obesity, as well as counseling and routine monitoring, at low or no cost.
Result FY 2011	923 blood pressure screenings were provided. Of 335 participants in DUHN communities, 239 were hypertensive. 50 physician referrals were made for high blood pressure or low heart rate. Belle Haven Senior Center was identified as a duplicative service (the area is well-served by Stanford Medical Center services) and was discontinued in May 2011, upon recommendation of the Director. In June 2011, six Senior Center Directors and 68 older adults participated in a written evaluation of the Sequoia Hospital screening and education programs provided at the community centers. Directors' comments highlighted the reliability, professionalism and convenience of the service, which promotes health self-management for their participants. The 68 older adults reported sharing screening results with their physicians 48 times. They rated convenience as the highest attribute of the program, reliability second, nurse one-on-one counseling third, and no cost fourth. Most participants were unable to describe the signs and symptoms of stroke. 240 flu and 10 pneumococcal vaccines were provided. The goal of 300 was not achieved due to number of county clinics being reduced from three to two and being scheduled later in the flu season. Health & Wellness initiated a Tetanus Diptheria Pertussis (Tdap) Vaccination 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 and served 233 individuals.

	Quarterly diabetes screenings were conducted at the Fair Oaks Intergenerational Center (94063 Redwood City) with the assistance of an interpreter. 20 screenings identified 10 individuals at high-risk who were referred to a physician. Biannual diabetes screenings were conducted at Twin Pines Adult Community Center in Belmont. 30 screenings identified 6 individuals at high- risk, and 2 were sent to their physician for follow-up. The Medication Management program was piloted at the Twin Pines Adult Community Center, with poor results due to lack of attendance. The program was suspended and will be re-evaluated. The county-wide campaign, San Mateo Hepatitis B Free, was temporarily suspended due to loss of leadership. Hep B vaccinations were not provided at the Health & Wellness Center in 2011. The State Hepatitis B Expansion Program was abruptly discontinued due to loss of funding.
Hospital's Contribution / Program Expense	Expenses: $18,919 offset by $7,654 income. Community Benefit Expenses: $10,537
FY 2012	
Goal 2012	To prevent cardiovascular disease and stroke by identifying individuals with hypertension or those at high risk for hypertension. To decrease the risk of illness and death among adults by vaccinating and educating as many individuals as possible, particularly those at high risk.
2012 Objective Measure/Indicator of Success	Provide monthly blood pressure screenings and education at five community centers for 220 participants per quarter. Provide quarterly diabetes screenings at two Adult Community Centers. Provide low-cost health screenings to a minimum of 60 individuals at the Health & Wellness Center. Provide 200 low-cost immunizations for flu and pneumonia. Provide 300 immunizations for Tetanus, Diptheria, Pertussis to community members. Offer 150 Tdap vaccinations for 7th and 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.
Baseline	Senior Centers do not offer blood pressure screening services. Monthly screenings give seniors a way to monitor their blood pressure and stay healthy, thereby promoting healthy aging in place. There is an identified need for Tdap inoculation of adults in contact with infants. There are no clinics in the area.
Intervention Strategy for Achieving Goal	Conduct Flu and Pneumococcal Vaccine Clinics at the Health & Wellness Center beginning October 2011. Offer screenings for high cholesterol, hypertension and diabetes, as well as counseling and routine monitoring, at low or no cost. Offer the RCSD Community Schools a Tdap clinic for 7th and 8th grade students who are not in compliance with the law that becomes effective 30 days after the start of the 2011-12 school year. Provide Tdap vaccinations for adults at the Health & Wellness bimonthly

	screening days. Provide Stroke Awareness Information and Medication Cards and monitor their use at monthly blood pressure screenings.
Community Benefit Category	A2: Community Based Clinical Services

COMMUNITY BENEFIT AND ECONOMIC VALUE

In Fiscal Year 2011, Sequoia Hospital provided $47,059,396 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.

9/15/2011
240 Sequoia Hospital
Complete Summary - Classified Including Non Community Benefit (Medicare and Bad Debt)
For period from 7/1/2010 through 6/30/2011

	Persons	Total Expense	Offsetting Revenue	Net Benefit	% of Organization Expenses	% of Organization Revenues
Benefits for Vulnerable						
Traditional Charity Care	1,252	1,251,097	0	1,251,097	0.6	0.5
Unpaid Cost of Medicaid	5,591	16,591,810	4,507,189	12,084,621	5.5	5.0
Community Services						
Cash and In-Kind Contributions	0	150,333	5,200	145,133	0.1	0.1
Community Benefit Operations	0	68,810	0	68,810	0.0	0.0
Community Building Activities	0	1,626	0	1,626	0.0	0.0
Community Health Improvement Servic	865	214,992	0	214,992	0.1	0.1
Subsidized Health Services	0	24,002	0	24,002	0.0	0.0
Totals for Community Services	865	459,763	5,200	454,563	0.2	0.2
Totals for Vulnerable	7,708	18,302,670	4,512,389	13,790,281	6.3	5.7
Benefits for Broader Community						
Community Services						
Cash and In-Kind Contributions	2,447	116,013	0	116,013	0.1	0.0
Community Building Activities	126	2,561,576	0	2,561,576	1.2	1.1
Community Health Improvement Servic	15,031	259,087	20,979	238,108	0.1	0.1
Health Professions Education	156	1,740,851	568,262	1,172,589	0.5	0.5
Totals for Community Services	17,760	4,677,527	589,241	4,088,286	1.9	1.7
Totals for Broader Community	17,760	4,677,527	589,241	4,088,286	1.9	1.7
Totals - Community Benefit	25,468	22,980,197	5,101,630	17,878,567	8.2	7.4
Unpaid Cost of Medicare	32,596	88,975,473	59,794,644	29,180,829	13.4	12.0
Totals with Medicare	58,064	111,955,670	64,896,274	47,059,396	21.5	19.4
Totals Including Medicare and Bad Del	58,064	111,955,670	64,896,274	47,059,396	21.5	19.4

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 to share this report as broadly as possible. Sequoia Hospital and the CAC plan to do the following in the coming months:

Sequoia Hospital's leadership team has an aggressive schedule of meetings and presentations to the community, including education, civic and service groups. Sequoia Hospital's Community Benefit Report will be an integral part of these presentations.

The Community Benefit Report will be posted and featured on the Sequoia Hospital web site http://www.SequoiaHospital.org.

The "Sequoia Insider," a biweekly employee newsletter, will include a description and highlights of the report. In addition, the newsletter will provide updates on Community Benefit activities throughout the year.

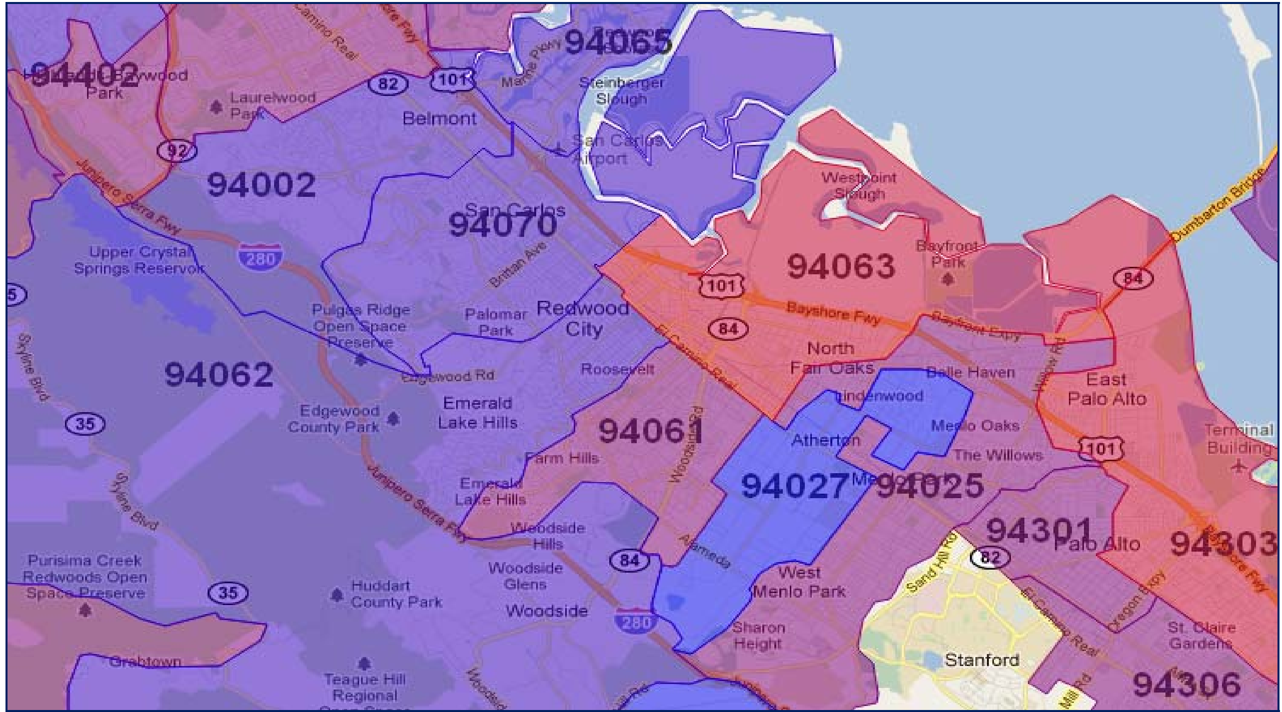
The Community Benefit Report will be highlighted in our online newsletter, Sequoia Health.

CAC members will work with staff to create a Community Benefit summary document to be distributed to the business community through Chambers of Commerce and to Sequoia Hospital patients upon discharge.

Metrics of Sequoia's key Community Benefit programs will be included in the Annual Mission Integration report to be distributed to selected hospital and CHW committees.

Attachment A

Sequoia Hospital



Lowest Need **Highest Need**

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

Zip Code	CNI Score	Population	City	County
94002	2.4	25460	Belmont	San Mateo
94010	2.4	40103	Hillsborough	San Mateo
94019	2.8	19945	El Granada	San Mateo
94022	1.8	18690	Santa Clara County	Santa Clara
94024	1.6	21991	Loyola	Santa Clara
94025	2.8	39362	Menlo Park	San Mateo
94027	1.6	7602	Atherton	San Mateo
94028	1.4	6899	Portola Valley	San Mateo
94030	3	21234	Millbrae	San Mateo
94040	3	31162	Mountain View	Santa Clara
94043	2.8	27394	Mountain View	Santa Clara
94044	2.6	36775	Pacifica	San Mateo
94061	3.2	35020	Redwood City	San Mateo
94062	2.2	26272	San Mateo County	San Mateo
94063	4	32576	Redwood City	San Mateo
94065	2.4	11702	Redwood City	San Mateo
94066	3	41709	San Bruno	San Mateo
94070	2.2	28149	San Carlos	San Mateo
94080	3.2	63919	South San Francisco	San Mateo

Attachment A

Zip Code	CNI Score	Population	City	County
94086	2.8	42705	Sunnyvale	Santa Clara
94087	2.8	49918	Sunnyvale	Santa Clara
94301	2.6	15958	Palo Alto	Santa Clara
94303	4	49546	Palo Alto	San Mateo
94306	2.8	25663	Palo Alto	Santa Clara
94401	3.8	33055	San Mateo	San Mateo
94402	2.6	23526	Highlands-Baywood Park	San Mateo
94403	2.8	38237	San Mateo	San Mateo
94404	2.6	32507	Foster City	San Mateo
94560	3.2	42224	Fremont	Alameda
95008	2.8	45254	Campbell	Santa Clara
95014	2.6	58422	Santa Clara County	Santa Clara
95051	3	55783	Santa Clara	Santa Clara
95125	3.4	50576	San Jose	Santa Clara

Attachment B

COMMUNITY ADVISORY COUNCIL ROSTER 2011

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Revised Oct 5 2011

Attachment C

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CATHOLIC HEALTHCARE WEST
SUMMARY OF PATIENT FINANCIAL ASSISTANCE POLICY
(June 2008)

Policy Overview:

Catholic Healthcare West (CHW) is committed to providing financial 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, CHW strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. Financial assistance is not considered to be a substitute for personal responsibility, and patients are expected to cooperate with CHW's procedures for obtaining financial 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 Financial Assistance:

- Eligibility for financial 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 financial 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 CHW 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 financial assistance and a determination of financial need occur prior to rendering of services. The need for financial 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 financial assistance becomes known.
- CHW's values of human dignity and stewardship shall be reflected in the application process, financial need determination and granting of financial assistance. Requests for financial assistance shall be processed promptly, and the CHW facility shall notify the patient or applicant in writing within 30 days of receipt of a completed application.

Patient Financial 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 determination 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 CHW 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 CHW 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 CHW facility.

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

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

- Information about patient financial assistance available from CHW, including a contact number, shall be disseminated by the CHW 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 CHW facility may elect. Such information shall be provided in the primary languages spoken by the populations served by the CHW facility.
- Any member of the CHW facility staff or medical staff may make referral of patients for financial assistance. The patient or a family member, a close friend or associate of the patient may also make a request for financial assistance.

Budgeting and Reporting:

- Specific dollar amounts and annual plans for patient financial assistance will be included within the Social Accountability Budget of the CHW facility. CHW facilities will report patient financial assistance calculated at cost in the annual Social Accountability Report and may voluntarily report such information as deemed appropriate.
- Patient financial 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:

- CHW system management has developed policies and procedures for internal and external collection practices by CHW facilities that take into account the extent to which the patient qualifies for financial assistance, a patient's good faith effort to apply for a governmental program or for financial assistance from CHW, and a patient's good faith effort to comply with his or her payment agreements with the CHW facility.
- For patients who qualify for financial assistance and who are cooperating in good faith to resolve their hospital bills, CHW 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, CHW management and CHW facilities shall comply with all federal, state and local laws, rules and regulations that may apply to activities conducted pursuant to this policy.